Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

Dramatically Improving the Patient Experience through Quality, Integration and Value

2013-2014 Annual Report

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Vision, Mandate, Mission and Values

Vision

A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Mandate

To plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services in Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk.

Mission

To ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.

Values

Respect; Integrity; Accountability

We work from the approach of being a catalyst for change; with a viewpoint based on the individual, and their caregivers, who need access to local health services.

To achieve this we are committed to:
Transparency; Collaboration; Innovation; Real Conversation

Message from the CEO and Chair

Twelve months ago – in our last Annual Report – we openly acknowledged that the current health care system has to work better for citizens and be better positioned to care for citizens. We knew then that we must turn the health care system on its head and shift the focus from providers to the **person.**

2013-2014 marked that first year of transformational change and growth for the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) organization and our health service providers. Our **Strategic Health System Plan** guided our work and ensured our gaze was, and continues to be, firmly focused on our strategic aim and strategic directions.

Strategic Aim
Dramatically improving the patient experience through Quality, Integration and Value.

Strategic Directions
1. Dramatically improving the patient experience by embedding a culture of quality throughout the system.
2. Dramatically improving the patient experience by integrating service delivery.
3. Dramatically improving the patient experience by evolving the role of the LHINs to become health system commissioners.

While we know there is a still lot of work to do, we have made significant steps in the right direction. Our Annual Report is an opportunity to bring a year's worth of work together in one place – to share with our community the work that has been accomplished and the work still underway. Here are just a few of the highlights you'll read more about in the pages ahead:

- **Quality** is front of mind as the HNHB LHIN continues to execute its Strategic Health System Plan. Staff and board focused on a number of initiatives including the establishment of the Quality Guidance Council, development of a LHIN-wide Quality Plan and the addition of a quality obligation within the Service Accountability Agreements.
- A consistent approach to **LHIN-wide integrated clinical programs** incorporating clear expectations, strong physician engagement and leadership, and strong administrative and organizational leadership achieved great success with measurable outcomes - Integrated Cancer Services Plan, Integrated Vascular Clinical Services Plan and Thoracic Clinical Services Plan.
- **Health Links** continue to rollout across the HNHB LHIN and the province. Eleven Health Links are planned for this LHIN and in 2013-2014 business plans for ten of those were submitted to the Ministry of Health and Long-Term Care.
- The **Behavioural Supports Ontario** strategy continued its focus on improving care and system navigation for individuals/caregivers who have, or are at risk of responsive behaviours. Collaboration among health service providers enabled radical change driven by a value statement which represents the voice of the individual with responsive behaviours.
- **Exercise and Falls Prevention Classes** are now offered by 17 providers across the LHIN at 175 locations - including 132 sites which had previously received classes by designated physiotherapy clinics - together these programs have the capacity to serve more than 11,000 residents.

As you can see from just the five examples above the HNHB LHIN staff and Board rely heavily on partners across our communities to improve the delivery of health care for our citizens. We sincerely thank and appreciate all of our health care partners for their dedication to improving the health care experience for the

citizens of our communities. Their hard work and determination demonstrates what is possible when we – the LHIN, health service providers, citizens and stakeholders – **work together with a common vision.**

We look forward to continuing on our journey together. The work we are doing continues to create a health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren. The work we are doing is dramatically improving the patient experience - thank you for keeping our patients and their families at the centre of your thinking and your work.

Sincerely,

Originally signed by

Donna Cripps
Chief Executive Officer

Originally signed by

Michael Shea
Board Chair

The HNHB LHIN Board of Directors

From left to right: Laurie Ryan-Hill, Michael Shea, Bob Lawler, Helen Mulligan, Ruby Jacobs and Mervin Witter.

Michael Shea, Chair

Appointed: October 28, 2010 • Term: 3 years
Appointed Chair: June 2, 2011 • Term: 3 years
Re-appointed: October 27, 2013 • Term: 3 years

Bob Lawler, Vice Chair

Appointed: October 29, 2008 • Term: 3 years
Appointed Vice Chair: June 2, 2011 • Term: 3 years
Re-appointed: November 30, 2011 • Term: 3 years

Ruby Jacobs, Member

Appointed: March 3, 2010 • Term: 3 years
Re-appointed: March 20, 2013 • Term: 3 years

Helen Mulligan, Member

Appointed: June 17, 2010 • Term: 3 years
Re-appointed: June 17, 2013 • Term: 3 years

Laurie Ryan-Hill

Appointed: May 17, 2011 • Term: 3 years
Re-appointed: May 17, 2014 • Term: 3 years

Mervin Witter, Member

Appointed: June 2, 2011 • Term: 3 years
Re-appointed: June 2, 2014 • Term: 3 years

Relationship Between the Board and Leadership Team

As of April 1, 2013, the HNHB LHIN Leadership Team included the CEO and Directors of Communications, Community Engagement and Corporate Services, Health System Transformation, Access to Care, Quality and Risk Management, Finance, and Physician Lead, Clinical Health System Transformation.

Leadership Team members attend the regular Board business meetings, including the Audit, and Quality and Safety Committees, as well as Board education meetings, and present monthly verbal and written reports to the Board on the activities in their respective portfolios.

Led by the CEO, the Leadership Team guides strategic operations of the organization and ensures the strategic aim and directions of the Strategic Health System Plan (SHSP) are at the forefront of the planning, integration and funding recommendations to the Board.

The Board provides ongoing direction to the CEO through:

- Regular business and education meetings,
- Board committees,
- Policy direction, and;
- Performance appraisal.

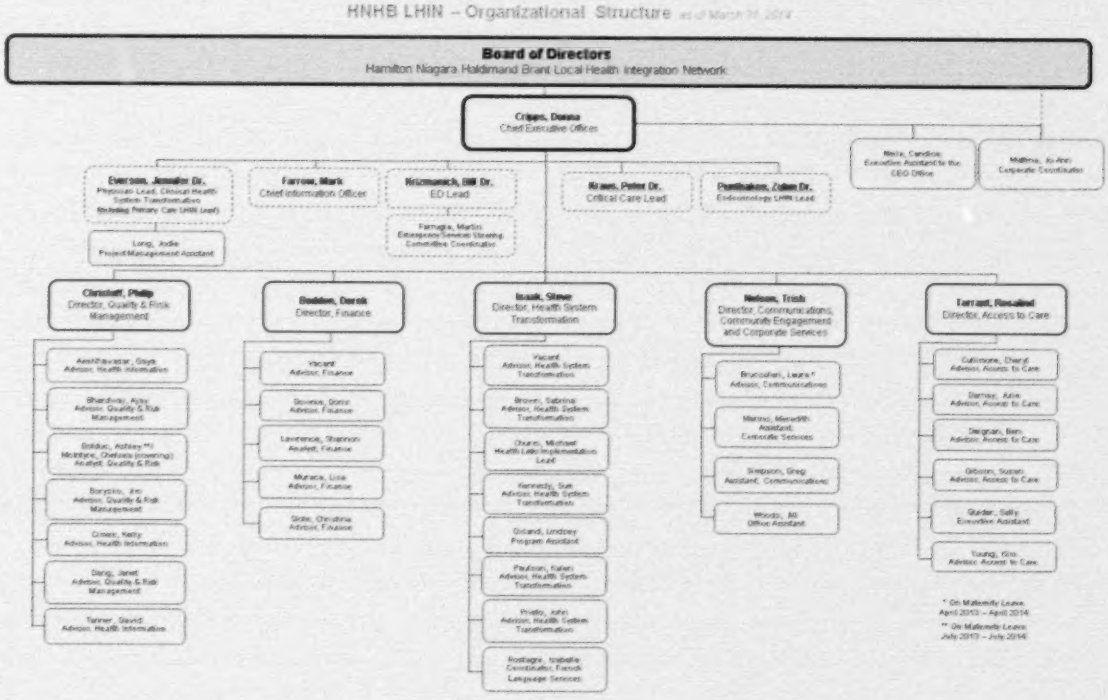
Continued Evolution of the HNHB LHIN

Our Organization

HNHB LHIN staff is committed to and passionate about working toward achieving the LHIN vision - a health care system that helps keep people healthy, gets them good care when they're sick, and will be there for our children and grandchildren – and the LHIN's strategic aim of dramatically improving patient experience through quality, integration and value. It is this vision and strategic aim that guide them in carrying out the duties of their roles.

The structure of roles within the organization is based on the core functions of the LHIN and maximizes the skills, knowledge and expertise of staff. Staff is committed to building capacity and sharing knowledge through training and education, and participation in local, provincial, and national activities.

Staff is guided by the values and principles of the organization including respect, integrity and accountability and to achieve this staff is committed to transparency, collaboration, innovation and real conversations.



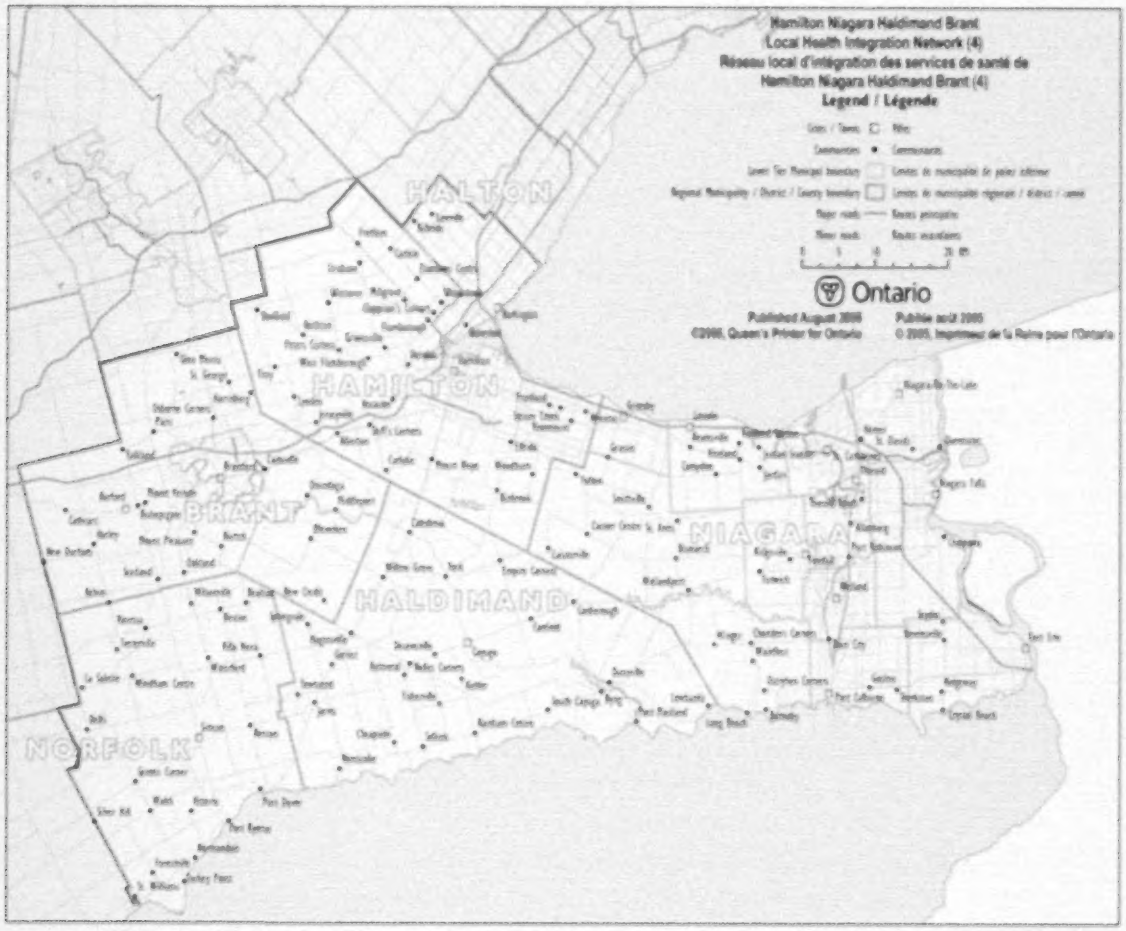
Snapshot of the HNHB LHIN

HNHB LHIN Population

Demographics

The HNHB LHIN is home to approximately 1.43 million people or 10.5% of the population of Ontario. The LHIN population is projected to grow 3.8% over the next five years and 8.4% over the next 10 years *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*

The LHIN's population is aging. As of 2013, over 240,000 people age 65 or older live in the LHIN and this number is projected to grow to over 285,000 in the next 10 years *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).* The population 65-74 years of age represents the largest number of people age 65 or older however the largest growth is projected among people 90 years of age and older (increasing by 57.7% over the next 10 years).



Socio Demographic Characteristics

The HNHB LHIN has a diverse population. For 18% of residents, neither English nor French is their first language. Francophone, First Nations, and urban and rural Aboriginal people are recognized populations in the HNHB LHIN. Compared to Ontario, the HNHB LHIN has a lower percent of immigrants and visible minorities.

About 2.2% of the LHIN population reported French as their mother tongue. Almost 80% of the Francophone population in the LHIN resides in Hamilton and Niagara. In addition, Welland and Port Colborne have the highest percent of Francophone population compared to the overall population among communities within the LHIN.

There are two reserves in the LHIN – Six Nations of the Grand River Territory, which has the largest population of all First Nation communities in Canada, and **Mississaugas of the New Credit First Nation**. The total registered Aboriginal population in the LHIN is approximately 24,000 people (1.7% of the total LHIN population), with about half the population living on reserve. Non-Status, Métis, and Inuit populations are not included in these population estimates *(Source: First Nations Peoples in Ontario: A Demographic Portrait. Ministry of Health and Long-Term Care, Health System Information Management and Investment Division. Health Analytics Branch, January 2009)*

The LHIN has a higher percent of lone parent families and a lower percent of adults with post-secondary education than the Ontario average.

	HNHB LHIN	Ontario
Total Population (2013)	1,436,963	13,632,450
Senior population, age 65+ (2013)	17.2%	15.0%
Population with English mother tongue	80.1%	69.8%
Population with French mother tongue	2.2%	4.8%
Population who are immigrants	20.3%	28.3%
Population who are recent immigrants (arrived between 2001-06)	2.3%	4.8%
Populations who are visible minorities	9.1%	22.8%
Population of Aboriginal identity	1.7%	2.0%
Labour force participation rate (age 15+)	65.7%	67.1%
Unemployment rate (age 15+)	7.1%	7.8%
Population in low income (before tax) all persons	13.7%	14.7%
Families (with children) headed by a lone parent	16.2%	16.0%
Population (age 25-64) without certificate, degree, diploma	14.6%	13.5%
Population (age 25-64) with completed postsecondary education	57.9%	61.4%

Sources: *Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO. ***2011 Labour Force Survey. Remaining indicators based on 2006 Census of Canada, Statistics Canada.*

Health Status

Self-reported health can show aspects of health not captured in other measures. More than 13.0% of LHIN residents rate their health as 'fair' or 'poor', which is higher than Ontario's rates. In addition, significantly more LHIN residents say they are limited in activities because of a physical or mental condition or health problem and have pain or discomfort that prevents them from engaging in activities *(Source: Statistics Canada, Canadian Community Health Survey, 2011-12).*

Illness, Disease and Death

LHIN residents have significantly higher incidents of arthritis/rheumatism, chronic obstructive pulmonary disease, and high blood pressure compared to the province as a whole. Rates of asthma and diabetes are slightly but not significantly higher than Ontario rates *(Source: Statistics Canada, Canadian Community Health Survey, 2011-12).*

Death rates reflect the overall health of the population. **Heart disease, lung cancer, and stroke were the top three leading causes of death.** Potential years of life lost rates are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e., before age 75). Deaths, potential years of life lost and hospitalization rates in the LHIN are higher than provincial rates *(Source: Death, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*

Health Practices and Preventive Care

Poor health practices, such as physical inactivity or poor dietary habits, may increase the risk of chronic disease, disability, and death. **Relative to the province, more people in the LHIN drink heavily and are obese** *(Source: Statistics Canada, Canadian Community Health Survey, 2011-12).*

Preventive health care services, such as good hand hygiene practices or regular health screenings, can help find disease early and over the long-term reduce illness and death. Of the selected preventive health indicators, none are significantly different from Ontario as a whole. Among women in the LHIN, 71.7% had a Pap smear (for cervical cancer screening) within the previous three years, 73.1% received a routine mammogram in the previous two years, and 32.6% had a flu shot in the past year *(Source: Statistics Canada, Canadian Community Health Survey, 2005, 2008, 2009-10, and 2011-12).*

Family doctors play a key role in coordinating care and managing chronic conditions. **The majority of LHIN residents, 79%, are enrolled with a family physician**, which is higher than the Ontario rate (73%). This excludes patients who receive their care from a Community Health Centre *(Source: Health Analytics Branch, Ministry of Health and Long-Term Care, February 2012)*

Summary

The LHIN covers approximately 6,500 km^2, encompassing Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk. With **approximately 1.43 million people**, it includes small rural communities and large urban centres, with a population that is culturally and linguistically diverse.

Relative to Ontario, the LHIN has a higher percent of:

- Lone parent families,
- People reporting 'fair' or 'poor' overall health,
- People limited in their daily activities,
- People who drink heavily,
- People who are obese,
- People with arthritis/rheumatism,
- People with chronic obstructive pulmonary disease;
- People with high blood pressure.

The LHIN also has:

- A higher rate of premature death and hospitalization; and
- A lower percent of adults with post-secondary education.

Engaging our Communities

Community engagement is a core function of the LHINs and is written into the *Local Health System Integration Act (LHSIA),* 2006 – the legislation that created LHINs. As part of its work, the HNHB LHIN engages a diverse range of people, including residents, health professionals, and those who are actively involved in the health system. This includes engaging with members of the Aboriginal, First Nations and Francophone communities. The LHIN recognizes, respects, and seeks to understand and address the unique needs of its diverse communities.

Aboriginal Health Engagement

The HNHB LHIN works with members of the First Nations and Aboriginal communities to identify and respond to the health needs of this diverse population. Through Aboriginal community engagement, the LHIN is learning how to best address gaps in health services. Respect for and inclusion of Aboriginal traditional practices within non-traditional health services is essential for the development of health solutions that are aligned with cultural identity, holistic health, and community values.

The LHIN's Aboriginal Health Network (AHN) provides a setting for Aboriginal health and social service organizations from across our region to collaborate with the LHIN to understand and address the health needs and issues of the Aboriginal communities. The AHN meets approximately 10 times per year.

In January 2012, the AHN identified three strategic priorities as part of a three-year action plan:

1. Reducing youth suicide and strengthening services to support youth mental health.
2. Reducing the Aboriginal rate of diabetes and other chronic conditions.
3. Reducing domestic violence and supporting strong, stable, responsible families.

The AHN worked towards reducing youth suicide and supporting youth mental *health by providing specific educational workshops and gatekeeper training programs. Gatekeeper training is a strategy that has been* recommended by the United Nations for suicide prevention, and has been shown to positively influence the knowledge, skills, and attitudes of trainees related to suicide prevention *(Source: Issac, M., et al. 2009. Gatekeeper training as a preventative intervention for suicide: A systematic review. Canadian Journal of Psychiatry, 54(4), 260-268).*

In 2013-2014, the LHIN provided funding for both Applied Suicide Intervention Skills Training (ASIST) Version 10 and Safe Talk Suicide Prevention gatekeeper training programs to Aboriginal health service providers (HSPs) and communities across the LHIN. The aim of ASIST is to help caregivers become willing, ready, and able to provide emergency first aid to persons at risk of suicidal behavior. SafeTALK is a program that trains community members to recognize persons with thoughts of suicide and connect them to appropriate suicide intervention resources. Trained educators delivered ASIST to 201 individuals and SafeTalk Suicide Prevention gatekeeper training to these 408 individuals. As of March 2014, approximately 30% of the initial training targets were achieved and 100% of the trainers received additional training to upgrade them to ASIST Version 11. These trainers are now equipped to educate others in our region about suicide prevention.

AHN, in partnership with Native Horizons Treatment Centre, trained 10 trainers in Mental Health First Aid (MHFA) as part of another mental health initiative. As a MHFA Canada Basic Course Instructor these

trainers are now certified to teach the MHFA Canada Basic course to members of the Aboriginal community. This course teaches how to provide initial help to people who are showing signs of a mental health problem or experiencing a mental health crisis, including those suffering from mental illness, mood disorders, anxiety disorders and psychosis. Those in the community that might begin to experience these issues can receive the proper care in a timelier fashion as a result of this training and earlier recognition of the situation.

Ongoing initiatives for reducing the rate of diabetes and other chronic conditions in the Aboriginal population focus on healthy behaviour change such as healthy eating, increasing physical activity, smoking cessation and stress reduction. The Walk the Talk Health and Wellness Program was undertaken by the AHN to exemplify leadership in promoting Aboriginal health to their service recipients. As of March 2014, the AHN Walk the Talk Health and Wellness Program achieved 88% participation by AHN organizational members.

Also in 2013-2014, the AHN, in partnership with De dwa da dehs nye's Aboriginal Health Centre, applied for and received base funding from the LHIN to support three full-time Aboriginal Patient Navigators. The Patient Navigators are intended to work with Aboriginal and mainstream health and social service organizations, the HNHB Community Care Access Centre (CCAC) and hospitals across the LHIN to help Aboriginal clients, caregivers and their families navigate the health care system after admission to hospital and to help ensure access to and provision of culturally appropriate health care services.

Utilizing Aboriginal engagement funds the AHN continued ongoing consultations with Aboriginal communities both on and off-reserve to explore strategies to include appropriate cultural practices to improve Aboriginal health outcomes over the upcoming year.

The AHN, along with De dwa da dehs nye's Aboriginal Health Centre and the Ontario Federation of Indian Friendship Centres, provided cultural sensitivity training sessions. A total of 14 Aboriginal cultural sensitivity training sessions were completed between August 2013 and March 2014. Attendees included LHIN Board and staff members, CEOs from other health service providers, executive directors and Health Link coordinators, Urgent Care Centres and emergency medical services, primary care and front line service providers. This training is designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Aboriginal people. The goal of the training is to further develop individual and organizational competencies and promote positive partnerships with Aboriginal service providers to improve Aboriginal patient care through effective communication and relationship building skills. 362 individuals participated in this cultural sensitivity training across the LHIN. This initiative has been received very positively by community partners and continues to build cultural sensitivity and cultural competency in the LHIN. This is crucial to providing the best care possible for Aboriginal people in a manner that considers and respects their culture and beliefs. This training provided the education necessary for non-Aboriginal people in service provider positions to accomplish these goals.

The AHN hosts a large community engagement event each year to consult with members living on and off reserve across HNHB with the focus on improving Aboriginal health across the LHIN area. This community engagement session provides a forum for educating the community about new initiatives, providing input into the 2014-2015 AHN strategic aims, and participating in activities to help improve the Aboriginal patient experience. This year's event included the launch of the new Walk the Talk Health and Wellness Program, which exemplifies leadership across the 15 AHN organizational members in a joint commitment to promote Aboriginal health to their staff and service recipients in the areas of nutrition, fitness, smoking cessation and stress reduction. The day also encompassed an interactive Aboriginal Health Fair involving over 27

Aboriginal service providers from across the LHIN area. Over 120 Aboriginal community members participated in this year's successful engagement session.

Francophone Health Engagement

The *French Language Services Act (FLSA), Ontario, 1986*, recognizes the contribution of the French speaking population to the historical, cultural, and linguistic heritage of Ontario. The *FLSA* guarantees the right of French speaking Ontarians to communicate with the government and receive services in French. To this end, the LHINs plan and promote French language health services, and engage the French speaking community in the process. French speaking residents and stakeholders know their communities best and the goal is to ensure the best outcomes for French language health services, acknowledging and respecting diversity within Francophone communities.

Partners in Health

The HNHB LHIN, Waterloo Wellington (WW) LHIN, and the *Entité de planification pour les services en français dans les régions de Waterloo, Wellington, Hamilton, Niagara, (French Language Planning Entity – 'Entity')* signed a five-year funding and accountability agreement starting April 1, 2011. The agreement sets out the roles and responsibilities of each party related to the provision of advice by the Entity on:

- Methods of engaging its Francophone community,
- The health needs and priorities of its Francophone community, including the needs and priorities of diverse groups within that community,
- The health services available to its Francophone community,
- The identification and designation of health service providers for the provision of French language health services in the HNHB and WW LHINs,
- Strategies to improve access to, accessibility of, and integration of French language health services in the local health system; and,
- The planning for, and integration of, health services in French in the HNHB and WW LHINs.

The accountability agreement required the establishment of a Joint Liaison Committee to develop appropriate mechanisms for ongoing dialogue and collaboration and the development of a Joint Annual Action Plan that sets out the objectives, priorities and actions each party will undertake in the current fiscal year.

Francophone Community Engagement

The LHIN participated in three meetings organized by the Entity to better understand the needs, concerns and preferences of French-speaking seniors in the Hamilton and Burlington areas related to access to long-term care homes. The LHIN surveyed and screened existing long-term care homes to gauge capacity and feasibility to develop a program culturally and linguistically adapted for residents who speak French.

The LHIN also participates in community meetings and events for the Francophone community to promote health services and programs and to listen to the needs of the population. The LHIN developed a brochure to list the programs and services available with the intention of informing the public on how the LHIN meets its obligations under the *French Language Services Act*.

The LHIN actively participated in Francophone collaborative planning discussions (such as Table interagence francophone du Niagara) that are part of the requirements of French Language Health Service Providers. FL HSPs must develop an engagement strategy to understand the Francophone community and

its stakeholders, and integrate their specific needs into the planning process. These engagement sessions were promoted as collaborative planning tables that allow providers to partner and promote their services within the community.

Listening and Learning

In response to an identified need, the LHIN provided $276,100 to the Centre de santé communautaire Hamilton/Niagara to provide mental health and addictions counseling services for French speaking individuals in both Niagara and Hamilton. In 2013-14 there were 750 visits, 310 individuals serviced and 40 group sessions.

Through the Multi-Sector Service Accountability Agreement refresh process, the LHIN engaged all health service providers to increase knowledge and awareness of French language services in order to improve access to quality health services in French and to assist them in planning and implementing French language services for their Francophone clients.

Physician Engagement

The HNHB LHIN has a variety of active physician networks involving primary care physicians and specialists. The Chief Medical Leaders (CML) group is comprised of the Chiefs of Staff, or the Vice President, Medical of each LHIN hospital. The CML met monthly and was involved with LHIN wait times, and access to care. The LHIN's strong physician engagement and participation has been a critical factor in the success and progression of the Strategic Health System Plan. Clinical integration opportunities were made possible due to considerable physician engagement and involvement (see page 19 for more details).

Physician engagement was critical to launching programs focused on ensuring the best emergency department care possible. This included Critical Link, a program that involved the partnering of small/medium sized emergency departments with large community emergency departments for the ongoing care of "semi-critical" patients (see page 43 for more details). Partnering with Critical Care physicians, as well as the CML, the LHIN rolled out the Life or Limb policy that ensures that people who suffer from a situation that endangers their life or a limb will receive immediate care in the hospital that can care for them. This is an example of providing the right care in the right time and in the right place (see page 44 for more details).

In this LHIN, Hamilton Health Sciences' Hamilton General site received the majority of Life or Limb patients. The Life or Limb Policy ensures that people who suffer from a situation that endangers their life or a limb will receive timely, appropriate care at the most appropriate hospital.

The Diagnostic Imaging Network (radiologists) worked collaboratively with their administrative leads to successfully reduce the Medical Resonance Imaging (MRI) and Computed Tomography (CT) wait times. Considerable work was done with regards to potentially reducing the MRI wait list across the LHIN. This included working with a subgroup of Orthopaedic surgeons to develop appropriateness guidelines for the use of CT/MRI versus plain film x-rays.

The LHIN's Primary Care Network consists of primary care physicians, as well as 11 family medicine Health Link leads. The Primary Care Network has several roles, which include providing advice to the LHIN, community, and hospitals, on potential new initiatives to improve the patient experience and assist family physicians with the care of their complex patients. Over the past year, they have assisted with the development of a discharge bundle, provided advice regarding the new LHIN-wide Esophageal Diagnostic

Assessment Program (EDAP), as well as providing feedback for the COPD Clinical Programs (to reduce the readmission of these patients) and providing suggestions on how to increase patient uptake at the Diabetes Education Programs (DEP) across the various Health Links. Working with the Primary Care Network, as well as the LHIN's Ontario Medical Association (OMA) representative, an event was held to bring community psychiatrists and family physicians together. This event provided the LHIN with excellent opportunities to improve access for mental health patients, specifically focusing on concurrent disorders and early intervention. This information has been shared with the HNHB LHIN Mental Health Advisory Committee and will be part of the development of 2014-15 objectives for the HNHB LHIN Chiefs of Psychiatry Working Group.

The implementation of Health Links has been a focus for this group and the success of having the family medicine leads of each Health Link meet monthly to share opportunities and review data and population health material cannot be underestimated.

An example of the quality deliverables for the Laboratory Medical Directors Network in 2012-13 was the standardization of several critical values across all LHIN hospitals. During a patient's hospital admission, or while in the emergency department, it is imperative that certain "critical blood values" are urgently communicated to physicians. A patient safety initiative was implemented to standardize these critical values, so that no matter where a physician was providing care, all labs would communicate these standard blood results. As physicians and health care students work in a variety of clinical settings, the Laboratory Medical Directors developed standard values to ensure the communication by the various labs across the LHIN is consistent. The success of this initiative led to several other blood results being standardized.

Health Professionals Advisory Committee

Since March 2008, the Health Professionals Advisory Committee (HPAC) has played an important role in bringing insight and perspectives to the HNHB LHIN. This committee focuses on opportunities to optimize interprofessional care and scopes of practice within the LHIN.

In 2013-14, HPAC agreed to focus on Mental Health and Addictions (MH&A) over the next two years. Numerous applications were received from allied health professionals, all interested in joining HPAC and its focus on MH&A. In April 2014, HPAC and its new members will begin to collaborate with the LHIN 4 Mental Health Advisory Group (comprised of CEOs and VPs from local hospitals and mental health community agencies) to create specific objectives for the next two years.

Strategic Health System Plan (SHSP)

The HNHB LHIN's Strategic Health System Plan (SHSP), is a five-year roadmap that will take the LHIN on a journey to a new health care system that dramatically improves the patient experience through quality, integration and value. The SHSP was approved by the LHIN Board at its December 12, 2012 meeting. The plans within the SHSP intend to embed a culture of quality throughout the care system, integrate service delivery, and evolve the role of the LHINs to become health system commissioners.

The SHSP intends to build an evidence-based, integrated and person-centred health care system, focused on:

- The health care experience of the individual,

- The health of a defined population; and
- The per capita cost for the population.

System-wide Quality Improvement

Throughout 2013-14, the HNHB LHIN engaged its health service providers and partners to advance system-wide quality improvement. The LHIN and its providers continue to come together to discuss the opportunities, partnerships and leadership required to advance quality improvement and health system transformation. This collaboration continued across the continuum of care through a variety of networks, including: Clinical Vice Presidents, members of the Long-Term Care Home Network, and executive directors of community health centres and mental health and addictions agencies.

Embedding a culture of quality is one of the LHIN's strategic aims. To do so, the LHIN has focused on a number of initiatives including the establishment of the LHIN's Quality Guidance Council, the development of a LHIN-wide Quality Plan and the addition of the quality obligation within Service Accountability Agreements.

Quality Guidance Council

The Strategic Health System Plan called for the establishment of a Quality Guidance Council to include providers from across the health care system, as well as experts to guide quality improvement implementation. The council is co-chaired by the LHIN CEO and the HNHB Community Care Access Centre (CCAC) CEO and membership includes representation from all sectors – hospital, long-term care homes (LTCH), Community Support Services (CSS) and mental health and addictions.

LHIN-wide Quality Plan

The Quality Guidance Council provided guidance and advice on the development of a LHIN-wide Quality Plan that incorporated Health Quality Ontario's (HQO) Common Quality Agenda for implementation April 1, 2014.

The LHIN-wide plan will focus on the patient experience and provide a strategic focus on bringing the patient voice to the forefront of health care delivery. This will be accomplished through sharing best practices between organizations, surveying patients in a consistent way, and involving patients in the design of all services.

Service Accountability Agreement Quality (SAA) Obligations

Included in the Multi-Sector Service Accountability Agreement (MSAA) and Long-Term Care Home Service Accountability Agreement (LSAA) are quality obligations that require health service providers to submit a completed quality plan by March 31, 2014 to the LHIN. These quality plans must include three components:

- Board Policy/Commitment to Quality,
- Balanced Scorecard that identifies measures and results; and
- A Quality Plan Narrative (outlines all of the actions/activities etc.).

This complements and builds on plans required by HQO and will ensure that all providers have solid plans in place to plan, measure and execute quality strategies.

Quality related resources were provided and updated as appropriate on the HNHB LHIN website to assist health service providers in how they address governance, measuring and monitoring, and action plans. These resources provide concrete examples of governance checklists and strategy planning, tips related to balanced scorecards that monitor quality initiatives, and quality plan templates that can help organizations embed a culture of quality. LHIN staff also participated in a number of sector specific events to speak about the LHIN's quality obligation and efforts to embed a culture of quality. These initiatives aligned with provincial strategies, as well as increased capacity to complete quality improvement activities in the LHIN and dramatically improve the patient experience.

Through this work the LHIN and health service providers:

- Advanced the focus on the patient perspective,
- Fostered innovative ways of thinking,
- Shared ideas and strategies; and
- Used data to drive change and patient care.

The LHIN continued to work with health service providers to set priorities consistent with system-wide goals and focused efforts on setting reasonable stretch targets to enhance patient safety and quality of care.

Integration - Health Links as a new model of integrated care delivery

Dramatically improving the patient experience by integrating service delivery begins at the local level - integrating care delivery for a group of individuals - one person at a time.

Ontario improved care for seniors and others with complex conditions through **Health Links.** This innovative approach brings together health service providers in a community to better and more quickly coordinate care for people who require significant health care.

Health Links are the cornerstone of the strategic direction to dramatically improve the patient experience by integrating service delivery.

People with the greatest health care needs make up five per cent of Ontario's population but use services that account for approximately two-thirds of Ontario's health care dollars. Better coordination of care for these people will result in better care and significant health system savings that can be devoted to other people, ultimately improving the sustainability of our health care system.

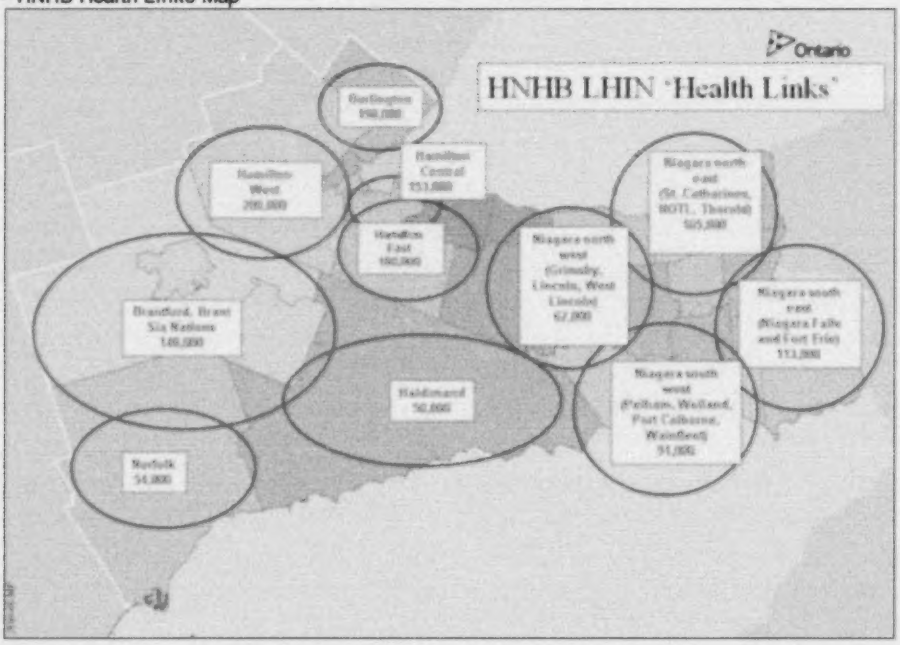
During 2013-2014, a number of key deliverables were achieved in support of the implementation of Health Links.

Foundational Work

Reflecting the geography and diversity of the HNHB LHIN population, the LHIN identified 11 prospective Health Links (the most of any LHIN in the province).

The LHIN supported each potential Health Link in highlighting population needs, opportunities, physician support and emerging partnership. These were criteria deemed necessary by the Ministry of Health and Long-Term Care (MOHLTC) to support implementation of the Health Link. Based on the outlined criteria, and as showcased within individual readiness assessments, the MOHLTC formally approved all as "official" Health Links.

Figure 1 – HNHB Health Links Map



Identifying the Health Link Person

The LHIN partnered with local experts and resources to identify those people who would most likely benefit from participation in Health Links. Based on data available from 2012, there were 2,292 "high users" identified across the LHIN. These people were included in this cohort based on meeting both of the following criteria - five or more emergency department visits and three or more hospital admissions in the past one year.

Health Links – Local Challenges, Local Solutions

The LHIN supported local partners in developing readiness assessments to highlight the fact that each Health Link had the necessary ingredients to be recognized as an official Health Link by the MOHLTC. The MMOHLTC subsequently formally approved all 11 Health Links as official.

The LHIN supported the Health Links in the development and submission of business plans to the MOHLTC (10 plans were initially submitted). The plans contained a number of initiatives focused on local challenges within each Health Link. These include:

- A Rapid Consult Model that allows family physicians to connect quickly and briefly with specialist physicians.
- Dedicated care coordinators to support Health Links patients in their journey through the system.
- e-Notification – an email or message is sent to a person's healthcare provider to ensure they are aware of those situations where a person visits an emergency department or is admitted to a hospital.
- Identifying Health Links patients within hospital and primary care systems (e.g. Clinical Connect) so that patients may be identified – and immediately supported – at points-of-care.

2013-14 Health Links Major Initiatives

Care Coordination

The LHIN explored care coordination across the province and encouraged local Health Links to adopt best practices with regards to person-centred care planning. The LHIN reached out to providers, partners, and stakeholders to begin the necessary conversations that would ultimately bring together the necessary care coordination that is at the centre of Health Links.

Enhancing Access to Specialty Care

When providing care to a person with complex needs, a family physician may need to seek the advice of a specialist for a quick discussion regarding the person's care. The LHIN developed a unique rapid consult model that allows family physicians to submit a question to a participating specialist via an online portal or through the telephone. A specialist then responds – often within hours – via an email or a telephone call. The rapid consult model allows patients to avoid lengthy wait lists and empowers family physicians to provide more comprehensive care to their patients.

Community Paramedicine

The LHIN facilitated partnerships between the Health Links and local Emergency Medical Services teams to explore expanding the role of paramedics, who bring a wealth of knowledge and experience, to better support the complex needs of patients. Emerging models within Health Links will often see paramedics visiting patients in their communities or at home to assist patients in better managing their chronic conditions.

Clinical Program Integration

Continued clinical services planning directly aligns with the HNHB LHIN's Strategic Health System Plan for a local integrated health care system where individuals experience care that is coordinated, of the highest quality, cost effective and results in better outcomes for the population.

The LHIN follows a consistent process to develop LHIN-wide integrated clinical programs. This process has achieved great success with measurable outcomes as evident through the Integrated Cancer Clinical Services Plan, Integrated Vascular Clinical Services Plan and Thoracic Clinical Services Plan. Success is attributed to a defined process with clear expectations, strong physician engagement and leadership, and strong administrative and organizational leadership.

LHIN-wide Integrated Clinical Programs

The key concept behind LHIN-wide integrated clinical programs is "one program on multiple sites." All residents across the LHIN should have access to a coordinated program with the same approach to care delivery and the same quality standards. This requires increased standardization and the reduction of clinical variation across providers, using:

- Common definitions and patient flow processes,
- Common care models and quality improvement process, based on leading practices; and
- Common outcomes, goals, deliverables and metrics.

Examples of how specific LHIN clinical services plans have demonstrated accomplishments include:

- The Integrated Cancer Clinical Services Plan established a single program of service delivery administered for patients at several sites across the LHIN.

- The Integrated Vascular Clinical Services Plan established a no refusal policy for vascular surgical patients with stringent monitoring to ensure patients have access to and receive appropriate care in the most appropriate location.
- The Thoracic Clinical Services Plan demonstrated a decreased length of stay for non-malignant thoracic surgical patients due to increased capacity through outpatient services at hospitals across the LHIN. This has been accomplished through collaboration with the HNHB Community Care Access Centre (CCAC) for in-home services and support.

Orthopaedics

Recognizing changes in demographics, service utilization, and delivery models, orthopaedic care has been a top priority for the LHIN throughout 2013-14. Within the first nine months of this fiscal year, more than 3,300 total joint replacements and 180 revisions were performed within the LHIN, involving 31 surgeons at seven different hospital sites *(Source: WTIS iPort Access (DTB010 Report))*. Demand for these procedures is expected to rise as a result of an aging population, estimated to increase by more than 50% by 2022. Orthopaedics must carefully look at how services are provided in the most effective and efficient manner.

The LHIN developed the Integrated Orthopaedic Capacity Plan (IOCP), with submission to the Ministry of Health and Long-Term Care (MOHLTC) in April 2013. This document outlines a plan of optimal resource utilization for primary unilateral hip and knee replacements, and identifies the measures by which accessibility and quality are monitored.

The IOCP guided specific initiatives to reduce variation and support best practices. These initiatives included the establishment of an Orthopaedic Leadership Committee comprised of administrative and physician leaders from all participating sites, as well as the development of standardized orthopaedic order sets, care pathways, and patient education material. Other initiatives from the IOCP identified the need for effective data management, strategies aimed at ensuring accurate wait time management and reporting reflective of system performance, and monthly meetings with hospital administrators and lead physicians to review performance indicators. Emphasis was placed on identifying opportunities for ongoing improvement and efficiency, including the way in which surgeries and wait times are booked and managed.

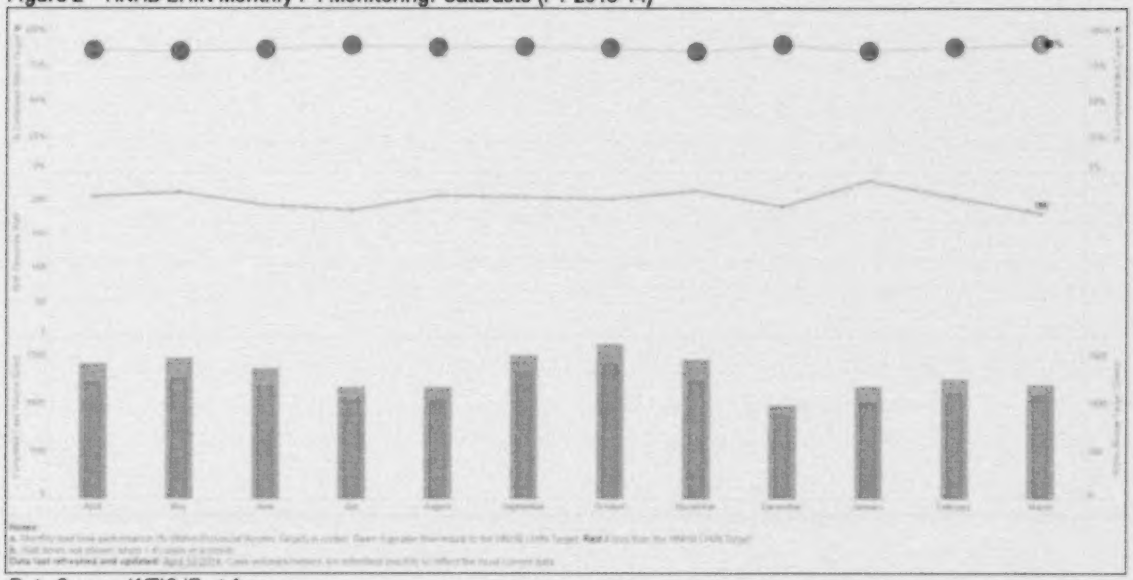
As a result, there was increasingly wide-spread participation in LHIN initiatives, including participation from all five sites in the Regional Joint Assessment Program (RJAP). Similarly, all five sites implemented strategies aimed at ensuring accurate wait time management and reporting, with some sites showing a marked increase in such practices over the last year. Through working with the hospitals and the HNHB CCAC, the LHIN demonstrated success in achieving targets for efficiency, effectiveness and safety.

The LHIN continued to work with hospitals and the HNHB CCAC on meeting and exceeding the targets provided in the Orthopaedic Scorecard, placing emphasis on wait time targets. Supported by outcome driven leadership and the integration of existing structures, the RJAP identified priority recommendations to further improve wait times.

Ophthalmology

A total of 14,504 Priority 4 cataract surgeries had been completed within the LHIN as of the third quarter of fiscal year 2013-14, improving people's vision and quality of life as a result of surgical services. Clinicians assess each patient and determine how urgent their need for treatment is, ranging from more urgent (Priority 1) to less urgent (Priority 4). Priority 4 is the least urgent, non-emergency cases.

Figure 2 – HNHB LHIN Monthly P4 Monitoring: Cataracts (FY 2013-14)



Data Source: WTIS iPort Access

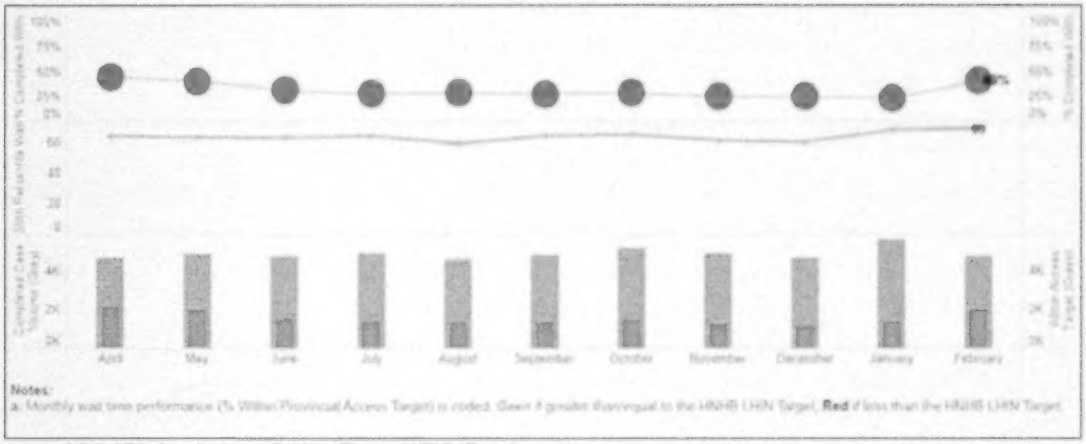
St. Joseph's Healthcare Hamilton was identified as the lead organization to facilitate use of evidence-based practices while standardizing clinical service delivery and providing ophthalmology specific physician and administrative leadership within the LHIN.

A LHIN-wide Ophthalmology Steering Committee was developed with physician and administrative representation from all five hospitals currently providing Ophthalmology services (St. Joseph's Healthcare Hamilton, Joseph Brant Hospital, Niagara Health System, Brant Community Healthcare System, and Norfolk General Hospital). The Committee reports to the LHIN and targets strategies to address wait times and standardized quality of care for patients. A LHIN-wide Integrated Clinical Services Plan was drafted for Ophthalmology services, with cataract surgery as a clinical priority for work in fiscal year 2014-15.

Diagnostic Imaging

A total of 53,434 Priority 4 Magnetic Resonance Images (MRI) had been completed within the LHIN as of February 2014 for fiscal year 2013-14, facilitating people's access to diagnostic services and treatments.

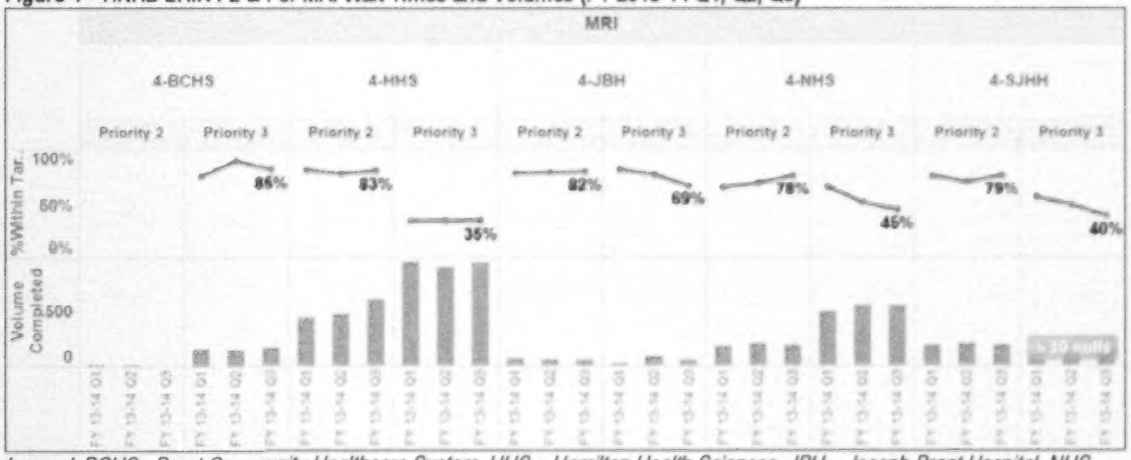
Figure 3 – HNHB LHIN Monthly P4 Monitoring: MRI (FY 2013-14)



Source: CCO ATC Surgical and DI Wait Times (WTIS iPort Access).

MRI 'blitz' funding was provided from the MOHLTC this year. Blitz funding focuses on providing additional, dedicated MRI hours to Priority 4 (non-urgent) patients, who have waited beyond the 28 day benchmark. An additional 2,000 hours of MRI service time was allocated based on patient need and hospital performance. A total of 8,180 Priority 2 and 3 (more urgent) MRIs were completed by the third quarter of fiscal year 2013-14.

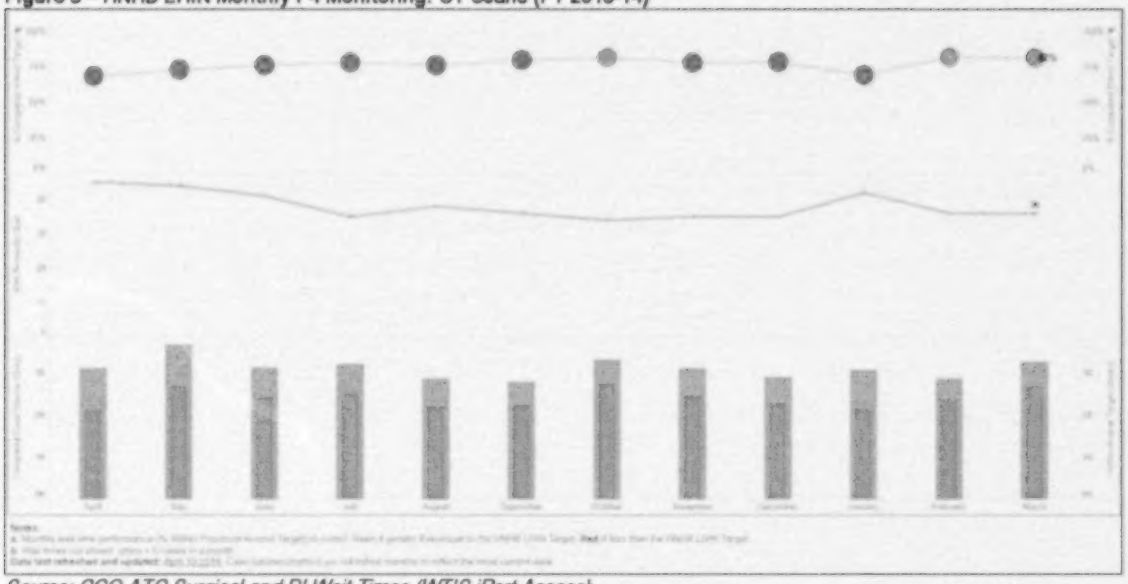
Figure 4 – HNHB LHIN P2 & P3: MRI Wait Times and Volumes (FY 2013-14 Q1, Q2, Q3)



Legend: BCHS - Brant Community Healthcare System, HHS – Hamilton Health Sciences, JBH – Joseph Brant Hospital, NHS – Niagara Health System, SJHH – St. Joseph's Healthcare Hamilton. Source: CCO ATC Surgical and DI Wait Times (WTIS iPort Access).

A LHIN-wide Diagnostic Imaging Steering Committee was formed, with representation from physician and administrative leaders across the LHIN. The Steering Committee, which reports to the LHIN, targets strategies to address waits times and standardized quality of care for patients. A total of 33,925 Priority 4 Computerized Tomography (CT) scans were completed by February 2014 of fiscal year 2013-14, improving access to diagnostic images to facilitate patient diagnosis and treatment planning.

Figure 5 – HNHB LHIN Monthly P4 Monitoring: CT Scans (FY 2013-14)

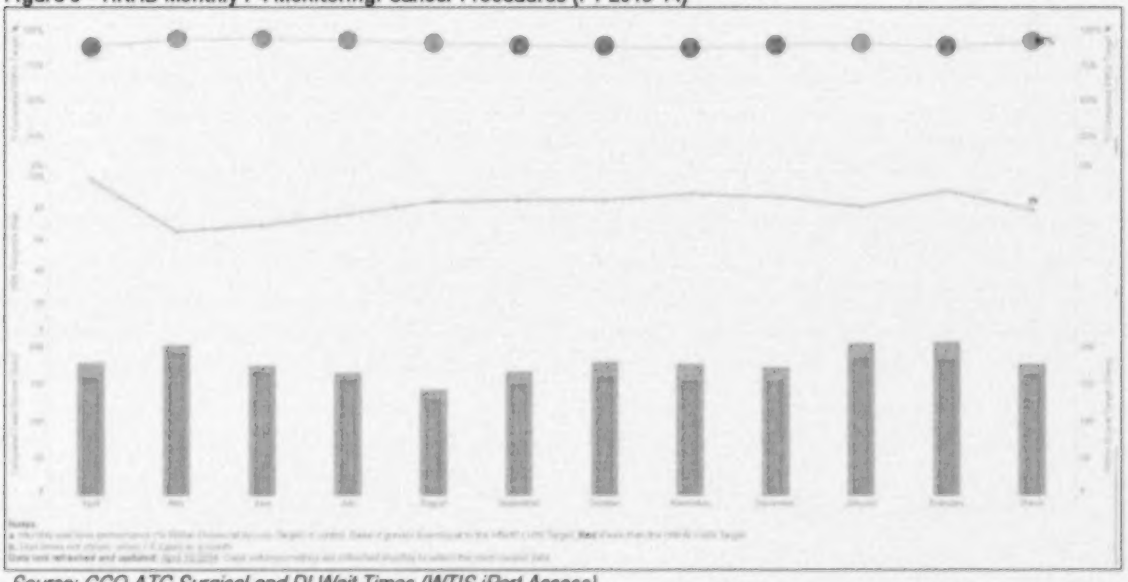


Source: CCO ATC Surgical and DI Wait Times (WTIS iPort Access).

Cancer Surgery

A total of 1,974 cancer surgeries were completed within the LHIN as of February 2014, for fiscal year 2013-14.

Figure 6 – HNHB Monthly P4 Monitoring: Cancer Procedures (FY 2013-14)



Source: CCO ATC Surgical and DI Wait Times (WTIS iPort Access).

Working with the HNHB Regional Cancer Program at Juravinski Cancer Centre the LHIN has facilitated the standardization of and improved access to cancer services, as well as a regular review of Cancer Care Ontario's quality metrics. The development of satellite centres in Brantford and Burlington, provided patients with treatment options closer to home. The opening of the Walker Family Cancer Centre at the

Niagara Health System St. Catharines Site on March 24, 2013 decreased the requirement for patients to travel to Hamilton for radiotherapy treatment.

Laboratory Services

The Hamilton Regional Laboratory Medicine Program (HRLMP) is one of the largest lab programs in Canada, serving six hospitals and performing 10.6 million tests annually. The Hamilton General Hospital, a site of Hamilton Health Sciences, houses the Microbiology Department of the HRLMP. Microbiology testing was consolidated from Joseph Brant Hospital to HRLMP and is now supported by a team of Medical Microbiologists, Infectious Disease Physicians and a laboratory operation that builds on critical mass and automation technology ensuring a consistent approach to the quality of Microbiology testing services. The HRLMP purchased and installed a Walk Away Specimen Processor (WASP) that has facilitated standardized and consistent, automated specimen processing, planting and streaking.

The HNHB LHIN Laboratory Network and Council is composed of leaders from all LHIN hospitals that provide laboratory services. Its purpose is to continue to work collaboratively to achieve an integrated Regional Laboratory System to provide consistent and standardized quality and care across all hospital laboratory sites. The HNHB LHIN Laboratory Medical Directors standardized critical laboratory values across the LHIN. Critical laboratory values are defined as values that are outside the normal/healthy range to such a degree that the patient's safety would be at immediate risk. All critical laboratory values that have been standardized have also received Medical Advisory Committee approval across all hospital sites.

Cardiac – Diagnostic Cardiac Catheterization and Percutaneous Coronary Intervention

In April 2013, a new integrated cardiac catheterization service opened at the Niagara Health System (NHS) St. Catharines site. This program was the culmination of more than three years of planning by physicians and senior administrators of the NHS and Hamilton Health Sciences (HHS).

During the planning and approval of NHS' redevelopment project, advances in technology and changes in medical practice improved the safety and effectiveness of Percutaneous Coronary Intervention (PCI). PCI evolved as a standard of care and where appropriate is performed at the time of cardiac catheterization. This practice has become an expectation for many clients/patients referred for diagnostic cardiac catheterization for assessment of coronary artery disease.

Working together HHS and NHS developed an integrated cardiac catheterization and PCI program that would be operated by HHS at NHS within a framework of one program on multiple sites. This approach:

- Improved patient experience,
- Improved Niagara residents' access to quality cardiac interventional care,
- Facilitated the development of a strong cardiac program in Niagara; and,
- Optimized available health human, capital and financial resources.

Key features of the integrated cardiac program model include:

- Appointment of one medical director for the integrated program,
- Joint recruitment of interventional cardiologists and common credentialing. Under this model one interventional cardiologist will be identified to work primarily at the NHS site, HHS' interventional cardiologists will have cross privileges to work at both sites proving a sustainable and stable interventional work force,
- Shared clinical manager,
- Centralized referral and triage process,

- Standardized referral and patient care processes that provide evidence based care,
- Shared policies, procedures and protocols,
- Common clinical policies, procedures, admission and discharge criteria,
- Establishment and use of sophisticated information technology structures; and,
- Common quality of care monitoring, reporting and identification with a commitment to joint monitoring of quality performance indicators.

As of February 2014, 1,119 cardiac catheterization procedures were completed at the NHS St. Catharines site. Beginning April 2014, PCI services will be provided at the St. Catharines site.

Health System Commissioners

A key strategic priority for the HNHB LHIN is to ensure accessible, patient-centered services that also reflect value for money. The LHIN maintains 191 Service Accountability Agreements (SAAs) with health service providers, and monitors fiscal and operational performance. The LHIN is also responsible for working with individual providers on key system-wide priorities, including emergency department (ED) wait lists, alternate level of care (ALC), and a shift of services from acute hospital to home and community care.

To drive a greater focus on value, the LHIN adopted commissioning best-practices (a proven international best practice in health care management) and became health system commissioners. Commissioning is a complex process with responsibilities ranging from assessing population needs and prioritizing health outcomes to procuring products and services and funding bundles of services. As health system commissioners, the LHIN staff and Board continued to enhance health system decisions based on evidence and performance.

Along the path toward adopting a commissioning strategy, the LHIN continued to enhance its relationship with health service providers and worked in partnership to meet their legal obligations. This included a performance management framework that answered the following key questions:

- Are health service providers delivering what they're supposed to be delivering? (Effectiveness)
- Are health service providers delivering services as efficiently as possible? (Efficiency)
- Are there some things that other health service providers can do better? (Quality)

The number and complexity of health service providers in the LHIN requires prioritization based on the risk of not meeting performance obligations. Enterprise Risk Management (ERM) is a strategic approach to identify, assess, mitigate and communicate key risks to the LHIN. A key strategic risk for the LHIN is ensuring that health service providers deliver high quality services effectively and efficiently in compliance with their accountability agreements.

A key strategic component in the advancement of the LHIN's role in commissioning is provider engagement. The LHIN developed and implemented an engagement plan aligned with Service Accountability Agreement negotiation timelines to ensure that significant performance issues are addressed at the time of agreement negotiations. The engagement plan involved strategies to focus on:

- Data quality – financial and statistical,
- Governance – ensuring a clear understanding of board's fiduciary responsibility for SAA management,
- Performance – the key organizational elements required to be in place to deliver value for money services ; and,

- Communications – clear, consistent messaging on performance improvement, the impact of not meeting SAA obligations and the negotiations involved in transfers and ceasing funding.

Successes in Commissioning

In September 2013, the LHIN allocated $29,347,400 million to community providers through a request for proposal process to target key priority populations. This exercise allowed the LHIN to focus funding directly on specific patient needs and link funding to high quality proposals that provided clear and deliverable outcomes and provided excellent value for the money invested.

In 2013-14, the LHIN worked with hospitals on the distribution of $6,847,000 in funding to directly impact wait time volumes for surgical procedures like cataracts and diagnostic imaging like Magnetic Resonance Imaging (MRI). This resulted in reduced wait times and increased access to health care for local residents.

The Board approved a Performance Accountability Policy that outlines principles to guide performance management. This policy sets out a clear relationship between the LHIN and providers, the role of governance in performance improvement and identifies the steps to address performance challenges.

The LHIN enhanced relationships with health service providers through planning and accountability meetings with all agreement types including hospitals, the Community Care Access Centre, community health centres, long-term care and other community agencies. Health service provider engagements included planning for patient care, quality improvement and performance metrics.

The LHIN developed and implemented a methodology to rank agency risk in order to proactively identify and mitigate performance and contractual issues. The framework was built on risk assessment across contractual compliance, performance indicators, and core financial indicators. This information identifies risks to LHIN staff and the Board, prioritizes interventions with non-compliant health service providers and ensures patients are receiving the best care at the most reasonable price point.

Home and Community Care Health Service Capacity

In June 2013, the HNHB LHIN hosted two Home and Community Care Investment Engagement sessions, which were intended to understand and prioritize system pressures and identify areas for new investments that would contribute to addressing these pressures. These two sessions were well attended, with 91 representatives from 89 health service providers. Through facilitated group discussions, system gaps were identified and many ideas were generated. Additionally, health service providers had the opportunity to provide input by submitting questions and suggestions through the LHIN website for three days following the sessions.

The engagement sessions and input received resulted in the development of priorities for potential investment. These priorities, which align with those of the LHIN and the Ministry of Health and Long-Term Care, were included in the LHIN's Request for Proposals:

Overarching Goals

- Improve patient flow and directly reduce the number of days individuals wait in hospital for an alternate level of care.
- Reduce the number of people readmitted to hospital or visiting the emergency department within 30 days of discharge from hospital.
- Support partners of Health Links to deliver care to the target/high needs populations.

Specific Initiatives

- Improve/increase system flow by focusing on initiatives that build capacity in services that can and should be accessed in the community and reducing utilization of hospital-based services:
    - Transitional Care,
    - Navigation - Early Intervention,
    - Crisis Response in the Community,
    - Withdrawal Management, Addiction and Concurrent Disorders,
    - Increase access in the community for people with mental health and addictions,
    - Transitions from hospital to the community,
    - Intensive Case Management,
    - Supportive Housing; and,
    - Respite Care.
- Support for the following High Risk Populations:
    - Mental Health and Addictions (MH &A),
    - Acquired Brain Injury (ABI),
    - Developmental Disabilities,
    - High Risk Seniors; and,
    - Transitional-Aged Youth.

The LHIN invited health service providers to submit proposals based on the above priority areas and overarching goals. The LHIN's review of 115 submitted proposals considered population health care needs, availability of services across the LHIN and the priorities of the LHIN and government. The Board approved the review process and decision making framework and staff brought forward 30 proposals for Board approval.

In 2013-14 the LHIN received $29,347,400 new base funding for home care and community services across the LHIN. This investment supported seniors and other individuals to receive care in their homes, reduced the time individuals with complex medical conditions wait for personal support services, reduced the time people wait in hospital for an alternate level of care, supported the partners of Health Links to deliver services to the target/high needs populations and decreased the number of people who were readmitted to hospital or visited an emergency department within 30 days of discharge.

This investment supported new or expanded programs and services across the LHIN for high risk seniors, those with complex medical conditions or requiring mental health and addition care, and increased access to assisted living supports and transitional beds.

Advancing Health System Priorities

Mental Health and Addictions

Strategic Alignment with Provincial Priorities

The successes over the past year are a reflection of the implementation of the guiding principles for mental health and addiction service delivery as outlined in Ontario's Comprehensive Mental Health and Addiction Strategy "Open Minds, Healthy Minds: Transforming Mental Health and Addictions Services in Ontario":

- Respect and understanding,
- Healthy development, hope and recovery,
- Person-directed services,
- Diversity, equity and social justice,
- Excellence and innovation; and,
- Accountability.

Mental Health in the HNHB LHIN

- 10-20% of residents will have a substance use disorder in their lifetime.
- 70% of people with mental health issues have been diagnosed before age 18.
- 98,000 children and youth do not get the mental health treatment they need.

Improved Access to Mental Health and Addictions Services

In 2013-14 $2.1 million in community investment funding was provided to programs and initiatives that support Ontario's Comprehensive Mental Health and Addiction Strategy. The funded projects and services demonstrate the LHIN's commitment to prevention, screening and assessment, navigation, treatment, case management, family and peer support, and workforce development initiatives. This funding will support:

- Prevention interventions for opioid dependent individuals,
- Intensive case management for mental health, substance abuse and concurrent Disorders,
- Patient navigators to support transitions from hospital to community,
- Mental health counsellors for Aboriginal youth,
- Withdrawal management screening and assessment for youth,
- Establish a residential and community withdrawal management program in Brant County with LHIN-wide integrated and standardized service delivery model,
- Expansion of early intervention programs,
- Expansion of crisis supports for mental health,
- Centralized access for Mental Health and Addictions,
- Regional DBT training for mental health; and,
- Regional Mental Health First Aid Training.

Building Capacity to Support Individuals with Mental Health and Addictions through Regional Collaboration and Integration

A LHIN-wide Mental Health and Addictions Advisory group, supported by the leadership of St. Joseph's Healthcare Hamilton, was established to implement integrated service delivery and has determined the following priorities:

Enhanced medical collaboration

- A regional Mental Health and Addictions physician group was established to improve mechanisms for improved collaboration between primary care and psychiatry.

Enhanced system performance

- Monitoring of performance indicators continued to determine strategies to achieve LHIN-wide targets for repeat emergency department visits for mental health and addictions issues.

Target priority populations

- A model for a regional concurrent disorders capacity project has been developed.
- A model for a regional early intervention program has been developed.

Enhanced collaboration and integration

- A model for a regional concurrent disorders capacity project has been developed.
- A model for a regional early intervention program has been developed.
- Mental Health and Addictions system integration demonstration projects will be implemented at the zone level.

With the opening in February 2014 of the new West 5th campus of St. Joseph's Healthcare Hamilton and the St. Catharines site of the NHS in March 2013, the LHIN has significantly expanded inpatient psychiatry capacity. Additional capacity exists at Brant Community Healthcare System and Joseph Brant Hospital.

One in five persons or 280,000 people, in the HNHB LHIN will be affected by mental illness at some point in their lives *(Source: Health Canada, A Report on Mental Illness in Canada, 2002)*. Approximately 42,000 people, or 3% of people in the LHIN, are dependent on alcohol or illicit drugs in a given year *(Source: Prevalence of Co-occurring Substance Use and other Mental Disorders in the Canadian Population, Canadian Journal of Psychiatry, December 2008)*. The investments made over the past year aim to make a difference in the lives of these people and their families.

Prevention and Management of Chronic Conditions

Advances in health care over the past several decades, specifically in the diagnosis and management of infectious disease and acute illness, have resulted in a dramatic improvement in life expectancies. Although Ontarians are living longer and healthier than ever, the vast majority of older adults have at least one chronic illness *(Source: Sinha (2012). Living Longer, Living Well: Recommendations to inform a seniors strategy for Ontario)*.

According to the Canadian Community Health Survey, 16.7% of the HNHB LHIN population has more than one diagnosed chronic condition such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes. This number is steadily rising due to the LHIN's aging population.

People with chronic conditions frequently interact with the health care system, whether at hospitals, walk-in clinics, or family doctors' offices. Therefore, the LHIN is developing programs to help people manage their chronic conditions at home.

Diabetes

During 2013-14, the LHIN assumed the funding and accountability for nine adult and four paediatric Diabetes Education Programs (DEPs) that were transitioned from the Ministry and Health and Long-Term Care (MOHLTC). In addition, the LHIN assumed a role to collaborate with health service providers across the LHIN, including primary care, with the purpose of improved coordination, standardization of

processes/practices and maximizing utilization to support a more integrated, patient centered system that is accessible, equitable and effective and offers the best value for Ontarians.

Diabetes in the HNHB LHIN

- As of March 31, 2014, the HNHB LHIN had 121,559 persons living with diabetes
- This represents 10.44% of the HNHB LHIN population and is the 3rd highest compared to all other LHINs

Over the past year, the LHIN worked together with health service providers to develop and implement several initiatives to improve the coordination and delivery of Diabetes Education Programs. A key component to advance these deliverables was expanding the Leaders in Diabetes group to include representatives from all DEP programs (MOHLTC and LHIN-funded). A Diabetes Action Plan was developed in collaboration with the Leaders in Diabetes group to guide activities in 2013-14. Key activities completed as of December 31, 2013 include:

- Increased access to specialized services and education through Ontario Telemedicine Network, with teleophthamology and education prioritized in 2013-14,
- Standardized reporting and targets for wait times,
- Completion of client satisfaction surveys and quality audits for DEP programs,
- Development of quality improvement initiatives driven from satisfaction surveys and quality audits,
- Identification of areas of potential underutilization or duplication of DEP services; and,
- Development of the diabetes webpage on the LHIN website to provide more information on the location and type of services offered at our DEPs.

The LHIN also developed an Action Plan that will continue to drive system improvements related to diabetes, including coordinated access, improved utilization and quality outcomes.

Access to specialized services such as foot care is an important component to the overall wellness of individuals with diabetes. The LHIN's Feet First program offers foot care assessments and follow-up treatments by a Registered Chiropodist and/or a Registered Practical Nurse to seniors with diabetes living in the community. Group education sessions and individual education to promote better foot care self-management are also provided in accordance with the 'Best Practice Guidelines for Diabetic Footcare' document *(Source: International Working Group on the Diabetic Foot, 2007. Best Practice Guidelines for Diabetic Footcare).* This document identifies the value of preventative measures to reduce the incidence of foot complications including leg ulcers and amputations.

In 2013-14, the Feet First program was expanded to provide service across the LHIN. The program served approximately 3,500 individuals (over 2,500 of whom were classified as "high risk"). Collectively these patients visited a foot care specialist nearly 11,500 times *(Source: Feet First Program Data extracted March 15, 2014).*

Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD), associated with frequent emergency department visits, hospital admissions and readmissions, was identified as one of the top medical conditions for acute hospitalizations in a review of the LHIN high user cohort for Health Links. As part of the 2013 Community Investment review, the LHIN received a proposal to establish an integrated care management program in Hamilton for individuals with COPD.

Implementation by LHIN Zone

- Hamilton – February 2014
- Brantford – April 2014
- Niagara – May 2014

In reviewing the Hamilton-focused proposal, the LHIN identified an opportunity to develop a LHIN-wide integrated model of care based on best practice and incorporating other COPD initiatives. This proposed strategy would support Health Links and LHIN-wide integrated clinical programs by enhancing case management and educating patients on self-management following hospital discharge.

To develop the community-based clinical service model, the LHIN recruited the expertise of leading respirologists and Health Links primary care physician leads from the three LHIN zones (Hamilton/Burlington, Brant/Haldimand/Norfolk, and Niagara). Once the core elements of the Caring for MY COPD program were identified, engagement sessions were conducted with health service providers and other stakeholders in each of the three zones to determine current resources for COPD and discuss potential partnerships and locations for the main program sites.

Additionally, patient engagement sessions were conducted in each of the three zones to ensure that patients and families were partners in designing the model of care. These sessions included individual interviews with patients and family members to better understand the patient experience, and group patient mapping exercises were conducted to improve our understanding of the patient journey in both hospital and community settings.

In February 2014 the Caring for MY COPD program began accepting patients in Hamilton. The program rolled out in Brantford in April and Niagara in May 2014. The Caring for MY COPD program provides a bundle of services to assist individuals with COPD and their health care team in increasing the individual's medical stability and capacity for managing COPD at home and in the community. The 8-10 week intensive part of the program will be provided to patients with mild to moderate COPD and includes education, exercise, assessments, mental health and wellness care, peer support and spiritual care and is followed by monthly telephone calls for one year. These aspects are combined with case management by a Certified Respiratory Educator (CRE) trained coordinator in collaboration with the primary care provider to reduce hospital admissions and emergency department visits. To learn more about the Caring for My COPD program visit www.hnhblhin.on.ca.

Stroke

The 2012 Ontario Stroke Network (OSN) Report Card identified several opportunities to improve stroke care in the LHIN. This report motivated the LHIN to collaborate with health service providers to develop regional strategies to improve stroke care. Opportunities to integrate stroke services within the three LHIN zones (Hamilton/Burlington, Niagara, and Brant/Haldimand/Norfolk) were identified.

Acute and rehabilitative care services are currently integrated at Hamilton Health Sciences, and plans are underway to increase collaborations to further integrate stoke services in Hamilton. The LHIN is also in the initial phases of engaging with senior leadership in the Niagara region to identify opportunities to integrate stroke services.

The most notable change in integrated stroke care in 2013-14 occurred in the Brant/Haldimand/Norfolk zone. The LHIN, Brant Community Healthcare System, Norfolk General Hospital and Central South Regional Stroke Network (CSRSN) collaborated to develop an integrated model for stroke care at Brant Community Healthcare System. This includes an integrated stroke unit (ISU) and the development of a community stroke rehabilitation model. Evidence has shown that individuals who have had a stroke and receive their acute and rehabilitative care needs in a designated stroke unit by a dedicated team of professionals are more likely to be alive, independent and living at home one year post stroke regardless of

age, gender or stroke severity *(Source: Stroke Unit Trialists' Collaboration. Organized Inpatient (Stroke Unit) Care for Stroke. Cochrane Database of Systematic Reviews 2007, Issue 4).*

Initial results indicate improved access to evidence-based care for stroke patients, as illustrated in Table 1.

Table 1: Integrated Stroke Unit Data

Outcome	2012-13 BCHS Site Results (April 2012 – March 2013)	BCHS Integrated Stroke Unit Results (July – Sept 2013)	Net Improvement
Percentage of stroke/transient ischemic attack patients treated on a stroke unit at any time during their inpatient stay	0.0%	91.4%	Increased 91.4%
Percentage of patients admitted to inpatient rehabilitation with severe strokes	51.7%	56.7%	Increased 5.0%
Percentage of ALC days to total length of stay in acute care	28.6%	11.2%	Decreased 17.4%

Sources: Brant Community Healthcare System (BCHS) Site Specific Report Card Year End 2012-13. Brant Community Healthcare System Site Specific Report Card Q2 2013-14.

The integration of stroke services at Brant Community Healthcare System has dramatically improved access to evidence-based stroke unit care, including acute and rehabilitative services. Stroke unit care has shown to reduce the likelihood of death and disability in men and women of any age regardless of stroke severity by as much as 30% *(Source: Stroke Unit Trialists' Collaboration. Organized Inpatient Stroke Unit) Care for Stroke. Cochrane Database of Systematic Reviews 2007, Issue 4).* Individuals treated in stroke units have fewer complications, earlier recognition of pneumonia and earlier mobilization. Integrated stroke care in the LHIN aligns with the Ontario Stroke Network's strategic priorities for fewer strokes and better outcomes.

Consultations with stroke survivors, caregivers and service providers revealed a lack of service coordination and follow-up after discharge from acute care and inpatient rehabilitation as well as challenges in identifying and accessing community services *(Sources: Anderson, S & Egan M. (2010), Models of Care Coordination Report, Ontario Stroke Network. Kelloway, L (February 8, 2012), Briefing Note to Genevieve Obarski, Change Foundation, Ontario Stroke Network. MacRae, L & Gould L (November 2011), Preliminary Report: Stroke Care in the Central South Region, Central South Regional Stroke Network).* To address these challenges, a community stroke rehabilitation model was developed to meet the needs of individuals, post-stroke following discharge from hospital. In December 2013, a pilot for the in-home community stroke rehabilitation model was launched in the Brant/Haldimand/Norfolk zone. As of March 2014, 11 individuals from this zone who live farther than 30 minutes away from an outpatient rehabilitation program and/or do not have the tolerance for travel have accessed community stroke rehabilitation in their home environment.

Palliative Care

In 2011, the Ministry of Health and Long-Term Care (MOHLTC) released a document entitled: Advancing High Quality, High Value Hospice Palliative Care: Declaration of Partnership and Commitment to Action in Ontario. This document has been used as a tool to help inform change and provide a framework for engaging more broadly with a wide range of stakeholders.

In 2013-14, Ontario LHINs collectively committed to recognizing palliative care as a priority for system transformation. The Declaration of Partnership document was used as the basis for broader regional consultation and planning discussions. Although different LHINs are at varying stages of readiness for palliative care action, all LHINs agreed to work towards having a regional program or network structure in place by March 2015 *(Source: LHIN Project Charter: LHINs' Leads and Provincial End of Life Network Meetings March 19, 2013).*

To support these priorities, the HNHB LHIN continues to work closely with the HNHB Hospice Palliative Care Network. Four Value Stream Mapping Process sessions were conducted to gather input and feedback on a draft model for a regional palliative care program. More than 150 people, ranging from senior management to front line staff, participated in this work.

Following the development of the draft regional model for hospice palliative care, additional briefing consultations were provided to more than 25 health service providers, Boards of Directors, HNHB Planning Networks, Family Health Teams and other stakeholders. More than 200 individuals were engaged in this consultation process and feedback was also sought through an electronic survey.

To advance the development of a regional hospice palliative care program structure, the LHIN identified the need for a Hospice Palliative Care Regional Council. The Council will act in an advisory capacity to the LHIN and be accountable to the LHIN CEO. The Council will recommend actions and activities to strengthen and develop a comprehensive integrated regional HPC program that is designed around the experience of patients, families and based on a foundation of involved and supported primary care. Recruitment for the Council was underway in April 2014.

Another achievement in 2013-14 was the incorporation of the advanced care planning and health care consent tool kit and e-learning module into the LHIN's Long-Term Care Home Service Accountability Agreement as a requirement for the Directors of Care, administrators and other key staff.

Behavioural Supports Ontario (BSO) Project

The Behavioural Supports Ontario (BSO) strategy for 2013-14 continued its focus on improving care and system navigation for individuals/caregivers who have, or are at risk of responsive behaviours. Re-designing and further integrating existing services to build a system around each patient is the underlying philosophy of the BSO approach. This radical change is enabled through collaboration among health service providers. Local activities for the BSO project have been driven by the following value statement which represents the voice of the individual with responsive behaviours:

"I am who I am so help me continue to be me."

In 2013-14, the HNHB LHIN focused on continued sustainability of four service models identified in the BSO Action plan, which was implemented in 2012-13. The LHIN was simultaneously exploring new opportunities for collaborations, innovations and encouraging small changes through quality improvement.

These models include:

- **BSO Connect** – A single point of information and referral (clients/caregivers/healthcare providers) providing active referrals, and pulling services towards clients. BSO Connect is operated by the HNHB Community Care Access Centre (CCAC).
- **BSO Community Outreach Team (COT)** – Five teams are located across the LHIN within existing community crisis teams providing 'just in time' (crisis) support to individuals with, or at risk of, developing responsive behaviours and linking them to longer term support.

> **"I appreciate everything you have done for me. I have never had anyone help me this much before."**
> BSO COT client

- **Integrated Community Lead (ICL) Service Model** –One community agency is the single point of contact for BSO clients. This model is being adopted by LHIN-funded health service providers who provide care to the BSO population.
- **BSO Long-Term Care (LTC) Mobile Team** – Five teams have been implemented across the LHIN, serving the LHIN's 86 long-term care homes.

Key successes over the past year:

- Supporting clients and their caregivers during transitions has increased for the BSO LTC Mobile Team related to new processes introduced (i.e. new referral form specific for transitions), rising from 99 in the previous fiscal year, to 448 in this past year.
- Responsive behaviour committees in long-term care homes have increased to 43 (from approximately five pre-BSO) with the facilitation of BSO's support. BSO staff participates at meetings to collaborate in developing care plans to address and reduce responsive behaviours.
- Ongoing stakeholder engagement of the long-term care sector has provided opportunities to make changes that improve communication to the Directors of Care regarding BSO involvement.
- BSO LTCH Hamilton team partnering with the McMaster Geriatric Fellowship program for shared learning, shadowing and building capacity that will lead to annual partnerships.
- 41 LHIN-funded community agencies, as lead organizations, continue to grow capacity within existing roles to embed the functions of the BSO ICL Service Model.
- Use of data to identify a gap in ICL agencies in three regions resulted in new funding to initiate new roles (intensive case managers).
- Building capacity in the Niagara region emergency departments regarding community resources or referral sources for clients with dementia.
- 25 tests of change (Plan Do Study Act cycles) and 16 new tools that help to make quality improvement in processes or support for the BSO population.
- On average, over 55% of clients had no services prior to calling BSO Connect. Through the Information & Referral staff at the HNHB CCAC these clients were connected to supports.
- As of March 31, 2014:
    - BSO Connect served 552 individuals.
    - BSO Community Outreach Team served 815 clients, linking them with longer-term support as needed.
    - 41 LHIN-funded agencies were operating as ICLs for the BSO population across the LHIN.
    - 18,707 client-based services were delivered to residents of long-term care homes from April 1, 2013 to March 31, 2014 *(Source: Program Reported Data March 31, 2014).*
- 1,379 referrals to the BSO LTC Model Team from October – December 2013.
- 1,348 clients benefited from navigational supports through the centralized referral process and the mobile community crisis worker linking the clients to services.

eHealth

The HNHB LHIN eHealth Office plays a lead role in harnessing information technology and innovation to improve patient care, safety and access for the residents of the LHIN in support of the government's eHealth strategy. Provincially, eHealth Ontario has evolved Ontario's Integrated Electronic Health Record (iEHR) Strategy, moving from a centralist model to one of regional hubs.

The HNHB LHIN eHealth Office manages the advancement of regional eHealth initiatives and priorities. The HNHB LHIN eHealth Office, in concert with Hamilton Health Sciences, are leaders in the advancement of eHealth systems and solutions which enable improvements in health care delivery, patient care and safety. The HNHB LHIN eHealth Office also works in partnership with LHINs, health service providers, the HNHB Community Care Access Centre (CCAC), eHealth Ontario, Connecting South West Ontario (cSWO), Health Links, and other partners to expand and leverage eHealth assets such as ClinicalConnect, Integrated Decision Support and provincial assets and systems such as Ontario Lab Information System, Resource Matching & Referral, Integrated Assessment Record, Client and Provider Registry, Ontario Drug Benefit and emerging Health Links care coordination tools.

The HNHB LHIN eHealth Office provides management services such as regional eHealth strategic planning, stakeholder engagement, communication, adoption, transformation and change management, proposal preparation and negotiation, program and implementation management and enhancement planning. The HNHB LHIN eHealth Office and Hamilton Health Sciences are solution providers in the context of cSWO and the HNHB LHIN eHealth Office is also a cSWO delivery partner for eHealth adoption and change management. cSWO is positioned to rapidly deliver a first generation iEHR (ClinicalConnect) for approximately four million Ontarians across southwestern Ontario that will span a significant portion of the continuum of care.

Integrated Decision Support Warehouse

The Integrated Decision Support (IDS) solution integrates and shares decision support information across health service providers in the HNHB LHIN and recently the Toronto Central and South West LHINs. Hospitals, CCACs, as well as some other health service providers contribute data and participate in using the HNHB LHIN's IDS data warehouse and Business Intelligence Solution. This solution helps enable participants to make informed, evidence-based planning and operational decisions for the residents within their region. This solution will help us understand how individuals are moving between health service providers and assist initiatives such as Health Links to identify the top 1-5% utilizing our health care system.

ClinicalConnect™

ClinicalConnect is a secure, web-based provider portal, or dashboard, that gives authorized physicians and health care providers involved in a patient's circle of care, real-time, anytime and anywhere access to electronically stored patient records. ClinicalConnect is an integration framework key to accessing and sharing health information regionally across the continuum of care including provincial data sources as they become available.

Today, ClinicalConnect provides a virtual Electronic Health Record (EHR) for HNHB and WW LHINs, representing more than two million patients. It links data from 28 hospitals across the two LHINs. It also includes oncology notes from the Juravinski Cancer Centre in Hamilton, the Walker Cancer Centre in St. Catharines, the Joseph Brant Hospital Cancer Clinic in Burlington, and the Grand River Cancer Centre in Kitchener, as well as information from the HNHB and WW CCACs. Across the HNHB LHIN over 7,000

health care providers are able to access over 14 million labs and reports per quarter, as well as share patient information in an expedited manner. As a result of patient information reaching their providers more quickly the proper care (encompassing all conditions and factors associated with the patient's health history) can be delivered earlier as well. This also prevents the duplication of referrals and test requests by creating more immediate communication amongst all members of the patient's care team.

Regional Diagnostic Imaging Project

Currently, ClinicalConnect includes diagnostic imaging or radiology reports, and in cases where they were performed at Hamilton Health Sciences, the image is available via a web-based image viewer. In spring 2014, access to images performed at other regional hospitals will be available upon completion of the Diagnostic Imaging Repository (DI-r) integration with ClinicalConnect. DI-r is a provincial initiative where hospitals provide diagnostic images to a regional database. In South West Ontario, all hospitals contribute images to a repository located and managed on their behalf by SWODIN, or the South West Ontario Imaging Network, located in London, Ontario. DI-r gives health care providers important information to make better decisions about a patient's treatment and reduces the need for patients to travel to see a specialist. This program improves patient care, safety and access by putting in place a stable technical infrastructure that guarantees that health care providers have access to vital clinical activity information systems when they need it.

eNotifications

Electronic notifications that let community physicians and the HNHB CCAC know almost immediately if one of their patients has had a hospital visit (emergency department, inpatient and outpatient). These are sent electronically through the existing ClinicalConnect integration. Patients will benefit from their care team understanding their interaction with the hospital in a timelier manner to better prepare for any adjustments in the patient's care planning. By having their community physician informed earlier, accurate patient information can be shared between care providers faster, resulting in the appropriate treatment. Previous notifications were made by telephone to the community physician's office and thus would not be received until the next morning, or couple of mornings if the visits occurred on a weekend.

Patient Flow

Patient Flow focuses on the transition of individuals across the health care system (continuum) from the community to acute in-patient hospital care, from acute to post-acute care or home. While it is not unexpected that situations will occur where individuals will experience a wait across the continuum, issues arise when individuals experience long waits in a hospital setting or when large number of individuals wait in hospital for a post-acute setting.

Individual Perspective	System Perspective
• Individual's recovery may be delayed or in the case of seniors may regress both physically and mentally while waiting for the appropriate post-acute care setting. • Unnecessary long hospital stays expose individuals to a higher risk of hospital acquired complications.	• Hospitals can become challenged if a high number of individuals that no longer require acute hospital care are waiting in hospital for an alternate level of care while other individuals need to be admitted for an acute illness or planned surgery. This may result in the cancellation of elective services, long emergency department wait times, or delays in receiving required services.

One of the metrics used by the HNHB LHIN to measure the number of days an individual waits in hospital for an alternate level of care (ALC) is the acute ALC rate. A low rate means that individuals spend less time waiting in an acute hospital for post-acute care. The post-acute care setting individuals wait for depends on their immediate and long-term care needs and include: post-acute restorative/convalescent care, complex care, rehabilitation services, home with community support services, mental health services, assisted living/supportive housing and long-term care home.

The LHIN monitors the number of days an individual waits in hospital for an ALC setting two ways:

- Closed cases - the total number of days that individuals have waited in hospital for an ALC setting by the time they were discharged.
- Open cases - the number of days that individuals still in hospital are waiting for an ALC setting.

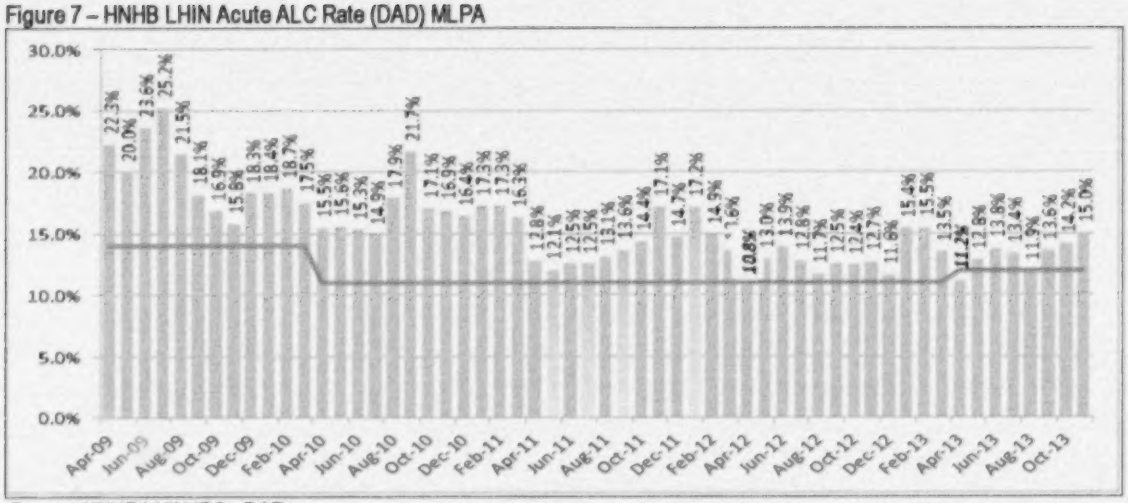
Patient flow was a significant priority for the LHIN in 2013-14 due to a number of system pressures that influenced patient flow and the ALC rate, notably:

- On April 7, 2013 the number of people waiting in hospital for an ALC was 409, this increased to 549 by February 9, 2014. This resulted in an increase in the LHIN's ALC rate from 12.8% in April 2013 to a high of 16.81% in February 2014 *(Source: HNHB LHIN Hospitals Weekly Trigger Report April 2014).*
- An increase in the number of people waiting in hospital for long-term care from 125 on April 7, 2013 to 190 on February 9, 2014 *(Source: HNHB CCAC Active ALC Count Feb 23, 2014).*
- Number of individuals newly designated ALC requiring a bed in a long-term care home but waiting in acute hospital beds increased in October and November 2013 (55 and 65 respectively) doubling the number designated in the previous three months (average 30 per month) *(Source: HNHB LHIN Patient Flow Steering Committee ALC Performance Monitoring February 2014)*

Despite the above challenges, the LHIN did see a number of successes over the past year:

- LHIN providers under the leadership of the HNHB LHIN Patient Flow Steering Committee completed the implementation of the LHIN's three-year Patient Flow Action Plan.
- Sustained reduction in the number of patients waiting in hospital for long-term care from 360 in August 2010 to less than 200 throughout 2013-14 *(Source: HNHB CCAC).*
- Demonstrated a decrease of 2,640 ALC days (33%) for the population aged 75-84 and 620 ALC days (8%) for the population 85 years of age during April– June 2013, compared to the same period in 2012 *(Source: WTIS ALC Accessed Nov 2013).*
- As of mid-March, 2014: 907 individuals were discharged from the LHIN's Assess Restore and Slow Steam Rehab programs and more than 80% of these patients were discharged home *(Source: HNHB CCAC Assess Restore Activity Report 2013-14 March 11, 2014).*
- Continued to support patients needing higher levels of community support to return home from hospital, between April – December, 2013:
    - 2,927 individuals supported at home on service maximums *(Source: HNHB CCAC 2013-14 Third Quarter Report).*
    - 1,047 patients discharged from hospital on Home First.
- Individuals have timely access to the most appropriate restorative type program (Complex Care, Convalescent Care, Assess Restore, Slow Stream Rehab and Complex Care Restorative Stream) as measured by a reduction in ALC days associated with these destinations.

Figure 7 – HNHB LHIN Acute ALC Rate (DAD) MLPA



Source: HNHB LHIN IDS - DAD.

The LHIN successfully continued to implement hospital and community-based strategies for improving patient flow, including the Discharge Transitions Bundle, the Rapid Response Transitions Team, continuing work with Restorative Care and Senior Friendly Hospital initiatives, and adding Assisted Living and Supportive Housing resources in the community.

Discharge Transitions Bundle

The Discharge Transitions Bundle (DTB) is a standardized process designed to prepare individuals for a successful transition home following an acute care hospital stay. The DTB specifically targets discharge planning for patients with Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure (HF), and includes: risk assessment tools, discharge instructions, Teach-Back components for both practitioners and patients, linkages to the HNHB Community Care Access Centre (CCAC) Rapid Response Transition Team to see clients in their home as early as 24 hours post discharge, medication reconciliation, and booked follow-up appointments with primary care within 1 week following discharge. The DTB was disseminated to all LHIN hospitals in 2013-14.

The DTB is intended to improve the patient's discharge experience and help prevent hospital readmission by providing patients with the information and education they need to manage their condition at home, what symptoms they need to look for and when to contact their physician, schedule follow up appointments with primary care prior to hospital discharge, review medications and if needed connecting the patient with the HNHB CCAC Rapid Response Transitional Care Team.

Rapid Response Transitions Team

This team consists of Nurse Practitioners and Registered Nurses that conduct in-home visits to clients referred to the rapid response transitional team program within 24 to 72 hours of discharge. The team provides an integrated and comprehensive approach to avoid emergency department visits and hospital admission, facilitate clients discharge home, improve integration with primary care and improve client outcomes.

From April through December 2013 2,466 patients were seen with 1,904 of these patients being supported in their discharge from hospital. This team has provided 2,417 visits by nurses and nurse practitioners, 279

visits by pharmacists and 57 visits for in-home diagnostic or laboratory services (*Source: HNHB CCACC Rapid Response Transition Teams – Quarterly Reporting to HNHB LHIN – Template for 2013/14).*

Assisted Living

In 2013-14 the LHIN approved $744,534 in community investment funding to support new and enhanced assisted living services across the LHIN.

Five organizations received funding to enhance their existing assisted living services programs. The LHIN also supported three new assisted living hub programs; two located in Hamilton and one in Burlington. The hub model provides outreach assisted living services to seniors in their own homes.

These programs allow seniors to remain in their own home knowing they can access support within 15 minutes of a phone call.

Senior Friendly Hospitals

The Senior Friendly Hospital (SFH) strategy remains an important provincial priority and is an enabler to support several provincial strategies, including Health Links and Ontario's Seniors Care Strategy.

The LHIN-wide SFH working group reviews hospitals' successes and key challenges in implementing SFH improvement plans. Six LHIN hospitals are currently participating in the provincial functional decline and delirium indicator pilot. Preliminary evaluation results and recommendations for broader implementation of the indicators will be available in 2014. The SFH working group's priorities for 2014-15 have been adopted as follows:

- Supporting Transitions in Care; and,
- Promoting Early Mobilization to Prevent Functional Decline.

The vision of SFHs is to enable seniors to maintain optimal health and function while they are hospitalized so that they can transition successfully home or to the next appropriate level of care *(Source: Senior Friendly Hospital Care Across Ontario. Summary Report and Recommendations, September 2011).*

Assess and Restore Approach - Restorative Care

The LHIN continued to support 124 restorative beds in seven locations across the LHIN to support individuals needing restorative programs to regain their optimal functional status following an acute illness. As of September 2013, 79% of individuals taking part in the restorative programs were discharged home. In the past these people would have been referred and deemed eligible for long term care placement. This program has contributed to improved patient flow and has been able to reduce the time other individuals wait in the emergency department for an acute care bed.

In January 2014, the LHIN received $1,079,300 in one-time funding to pilot an assess restore mobile model at Hamilton Health Sciences, St. Joseph's Hamilton Healthcare, Joseph Brant Hospital and Brant Community Healthcare System. This program provides hospitalized seniors, who are at risk of functional decline or have experienced functional decline and have restorative capacity, with access to a dedicated inter-professional team-based integrated model.

The care team develops and provides an intensive, time-limited restorative program that targets the patient's specific recovery needs (i.e. increasing strength, activities of daily living abilities and mobility) with the goal of earlier discharge home with or without supports. The interventions are provided to patients in

their current location (i.e. emergency department and acute inpatient). Patients requiring access to in-home or clinic-based rehab are identified and early referral to the HNHB Community Care Access Centre (CCAC) or outpatient rehabilitation is initiated.

In 2013-14 convalescent capacity within the LHIN was also increased to 63 beds by funding an additional 28 beds (eight in Hamilton and 20 in Niagara). Convalescent care provides short stay supportive care to assist people who need time to recover strength, endurance or functioning for up to 90 days. The convalescent care program expands the range of options for individuals who do not need acute care but cannot yet manage at home.

Emergency Department Length of Stay

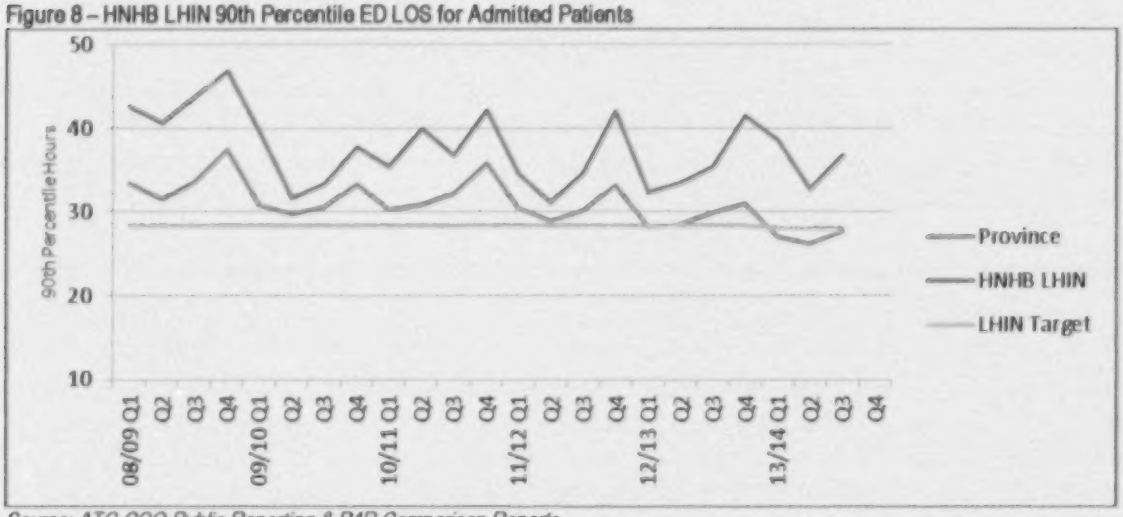
There are nine hospital corporations within the HNHB LHIN; these include two academic centres (one multi-site), three large community hospitals (one multi-site), one chronic care hospital and three small community hospitals serving rural areas. Eight of these hospitals provide emergency services across twelve sites, eight participate in the Ministry of Health and Long-Term Care's (MOHLTC) Pay for Results initiative and one has a dedicated emergency department (ED) for children and youth.

The ED length of stay (LOS) reflects the amount of time individuals spend in the ED, from the time they register or are triaged (whichever occurs first) to the time when they leave the ED or are admitted to an inpatient hospital bed. During this time, the person sees the medical staff and receives care.

How is ED LOS measured?
90th percentile, which is the time it took the ninth person out of ten to receive care.

The LHIN has experienced difficulty in improving ED LOS for the admitted patient population despite participating in the MOHLTC's Pay for Results initiative (see page 43 for more details) and implementing an aggressive patient flow strategy. A review of the LHIN's performance for ED LOS for admitted patients shows seasonal increases during the fall and winter months, which is similar to the provincial pattern. However, overall performance in ED LOS for admitted patients among LHIN hospitals remains higher than the provincial average (see Figure 8).

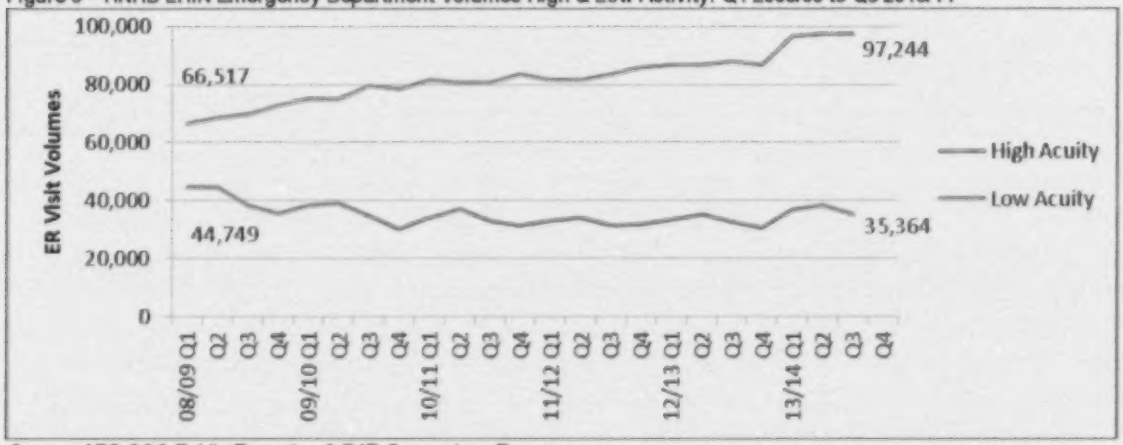
Figure 8 – HNHB LHIN 90th Percentile ED LOS for Admitted Patients



Source: ATC CCO Public Reporting & P4R Comparison Reports.

There are a variety of health system pressures that have made decreases in ED LOS challenging. Hospitals in the LHIN are experiencing an increased number of higher acuity people than in previous years. In 2013-2014, LHIN hospitals reported an overall increase in the number of ED visits. As of February 2014, LHIN hospitals reported 486,200 visits *(Source: ATC CCO ER Public Reporting & P4R Hospital Comparison Report March 2014)*, which is 48,800 additional visits over the same period in 2012-13 *(Source: ATC CCO ER Public Reporting & P4R Hospital Comparison Report March 2013)*. Much of the overall increase in ED visits can be attributed to the high acuity population who are classified by the Canadian Triage and Acuity Scale (CTAS) as CTAS 1-3 (see Figure 9). The number of patients presenting to the ED with low acuity (CTAS 4-5) has gradually decreased over time. The portion of the population demonstrating the greatest increase was aged 65 years and older.

Figure 9 – HNHB LHIN Emergency Department Volumes High & Low Activity: Q1 2008/09 to Q3 2013/14



Source: ATC CCO Public Reporting & P4R Comparison Reports.

Table 2 shows a comparison of the ED admitted population comparing April-December 2013 to the same period in 2012 *(Source: NACRS, HNHB LHIN IDS. Accessed January 2013)*. The LHIN geography showing the highest increase in ED admissions was the Hamilton area (5.9% increase in volume compared to LHIN-wide net increase of 1.2%).

Table 2: Comparison of ED Admitted Population from Q1-Q3 2012/13 to Q1-Q3 2013/14

Indicator	April – December 2012 (Q1-Q3 2012/13)	April – December 2013 (Q1-Q3 2013/14)	Net Change
Number of Patients Admitted through ED	52,965	53,619	+1.2%
CTAS 1	2,607	2,910	+11.6%
CTAS 2	21,563	22,932	+6.3%
CTAS 3	26,257	25,670	-2.2%
CTAS 4-5	2,515	2,095	-16.7%
Unknown/Missing CTAS	23	12	-47.8%

Key Activities to Reduce ED Demand and ED LOS

Pay for Results

Eight ED sites across five hospital corporations participated in the Ministry of Health and Long-Term Care's (MOHLTC) Pay for Results (P4R) program. Based on the previous years' performance on five specific indicators, hospitals receive one-time funding to implement patient flow strategies which focus on further reducing the time people spend in the emergency department. These initiatives included Rapid Assessment Zones for low acuity patients, Patient Flow Coordinators, enhancing ED support services, additional Triage Nursing time, and additional ED Physician hours.

P4R participating HNHB LHIN hospitals:

- Brant Community Healthcare System
- Hamilton Health Sciences
  - Hamilton General Hospital
  - Juravinski Hospital and Cancer Centre
  - McMaster Children's Hospital
- Joseph Brant Hospital
- Niagara Health System
  - St. Catharines Site
  - Niagara Falls Site
- St. Joseph's Healthcare Hamilton

Community Care Access Centre (CCAC) Care Coordinators

Large EDs within the HNHB LHIN have Care Coordinators from the HNHB CCAC working within them. A comparison of HNHB CCAC data from April to September 2013 compared to the same time period in 2012 yields the following results:

- Hospital referrals to HNHB CCAC increased by 19.6%.
- 48.6% of this increase was due to referrals directly from the EDs.

As of January 2014, 4,119 *(Source: HNHB CCAC Monthly Report January 2014)* potential hospital admissions were avoided because HNHB CCAC care coordinators located in emergency departments arranged for care to be provided in the community rather than in hospital. This means patients were not admitted to hospital and were able to return home to receive appropriate treatment.

Screening Tool for High Risk Seniors

The LHIN, hospitals and the CCAC worked together to implement an evidence based screening tool to identify seniors who may be at high risk and need community supports.

In 2013-14, 4,331individuals were screened and identified as high risk, 2,520 were not known to CCAC, were assessed for community services and were connected with a care coordinator. Of these, 1,065 were offered services through the HNHB CCAC *(Source: Early Intervention Screening 2013/14 YTD Summary)*. The LHIN successfully implemented the screening tool across all hospital EDs.

Access to Urgent Care Centres

There are six urgent care centres in the LHIN – two in Hamilton, three in Niagara and one in Paris. Residents with less acute health care needs can be treated at an Urgent Care Centre faster than in an emergency department which helps to decrease the demand on hospital EDs. From April 2013 to December 2013, LHIN UCCs reported 105,736 visits to five of the six clinics. The Urgent Care Clinic at the Niagara Health System St. Catharine's Site is part of the ED and thus its volumes are included in the ED's volumes.

General Internal Medicine Rapid Assessment Clinics (GIMRAC)

The two GIMRACs located at Hamilton Health Sciences' McMaster Site and St Joseph's Healthcare Hamilton's Charlton Campus continued to see increased demand in 2013-14.

The clinics facilitate access to General Internal Medicine (GIM) consultations through an out-patient clinic. The clinic reduces overall ED length of stay at these hospital sites by providing rapid access to GIM physicians, thereby allowing ED physicians to safely discharge patients that can be seen on an out-patient basis rather than waiting in the ED.

As of September 2013, the clinics reported 2,022 new clients, 745 of whom returned for a follow up visit. 298 visits were considered ED diversions and 239 were discharged early from the hospital. St. Joseph's Healthcare Hamilton reported a 71.2% reduction in the ED length of stay for patients who were referred to the clinic in order to see a GIM consult compared to those stayed in the ED in order to receive a GIM consult *(Source: Quarterly Performance Reports Q2 2013-2014 HHSC & SJHH).*

Emergency Services Steering Committee

The Emergency Services Steering Committee (ESSC) provides leadership to LHIN health service providers and the LHIN organization in the planning and implementation of initiatives to improve service quality and wait times for emergency services across the LHIN.

In 2013-14, a number of projects were funded to improve the patient experience:

- ED Coaching Team Program - an external team whose collective expertise was requested to help identify specific needs, barriers, and objectives for improving the coordination and flow of ED admitted patient populations at a LHIN hospital
- McMaster Emergency Medicine Research Group (MEMRG) - evaluated and measured best practice performance of the 6 LHIN hospitals where opioids were frequently used as the primary treatment of migraine
- St. Joseph's Healthcare Hamilton improved the Initial Assessment Physician process and the overall patient experience by reducing times from triage to physician initial assessment.
- Niagara Emergency Medical Services (EMS) continued to work on the OMEGA project, which is a strategy for improving utilization of emergency department resources by finding alternative medical pathways for non-urgent patient groups.
- The HNHB CCAC piloted sustainable care and communication practices to avoid unplanned emergency department use among long-stay home care patients (on service more than 60 days). Care protocols now involve HNHB CCAC Rapid Response Nursing resources and communication between community care providers such as home care, primary care, and medical specialists.
- The Central South Infection Control Network conducted a full day workshop for health service providers to heighten awareness of the constant need for risk assessment and use of routine practices to ensure safe patient care.

In addition the LHIN supported a Process Improvement Facilitator with expertise in change management, Six Sigma and Lean methodologies to work with a LHIN hospital challenged with persistent high ED wait times for their admitted patient population.

ED Critical Link

This program started on April 2, 2013 and involved the partnering of small/medium sized emergency departments with large community emergency departments for the ongoing care of "semi-critical" patients that do not meet the requirements of a life or limb policy or regional program acceptance policy. While this program is unique to the LHIN, it is being considered in other parts of the province.

The model includes the following:

- Direct ED physician to physician discussion, consultation and possible referral to determine management plan and disposition.
- CritiCall is involved in all ED to ED discussions to assist in physician to physician contact and to ensure that an appropriate resolution is determined.

From April 2013 to December 2013, the Critical Link Program was activated for 39 patients; 33 required transfer to another site, and six were able to be treated at the original site after consultation with the ED physician at the partner site.

Life or Limb

The Life or Limb policy ensures that people who suffer from a situation that endangers their life or a limb will receive immediate care in the hospital that can care for them. This provincial policy was activated in January 2014 and 97 cases in the LHIN have been referred through CritiCall, as of March 31, 2014, as part of the new Life or Limb policy.

The Life or Limb policy has the following guiding principles:

- The Provincial Life or Limb Policy is in effect when a patient is life or limb threatened and therapeutic options exist, which are needed within four hours.
- A patient's life or limb threatening condition is a priority and the identification of beds is a secondary consideration and patients with this condition are not refused care.
- LHIN geographic boundaries do not limit a patient's access to appropriate care in another LHIN.
- Repatriation within a best effort window of 48 hours once a patient is deemed medically stable and suitable for transfer is critical to ensuring ongoing access for patients with life or limb threatening conditions.

Physiotherapy Reform

In 2013, changes were made to Ontario's publicly funded physiotherapy programs. These programs are intended to keep seniors active, which has been demonstrated to reduce emergency department visits and hospital admissions.

The five areas of change included:

- Exercise and Falls Prevention Classes – the LHIN initiated a request for proposal process for community providers of exercise and falls prevention classes. As a result, 17 providers now offer exercise and falls prevention classes at 175 locations across the LHIN. This includes the 132 sites that previously received classes by designated physiotherapy clinics and have transitioned to LHIN-funded agencies. Together these programs have the capacity to serve over 11,000 residents.
- In-Home Physiotherapy – the HNHB CCAC is now the sole provider of in-home, one-to-one physiotherapy. The HNHB CCAC engaged all retirement homes and seniors' buildings within the LHIN to ensure that all seniors who were receiving physiotherapy services continued to receive their care. As of March 31, 2014, the HNHB CCAC provided in-home physiotherapy services to 765 clients.
- Long-term care homes receive direct funding to arrange for the appropriate physiotherapy services that meet the needs of their residents.
- Clinic-based physiotherapy – as of August 21, 2013, designated physiotherapy clinic services transitioned to a contract -based framework for service delivery with the MOHLTC. This process allowed previously existing physiotherapy services to be maintained in communities. A call for

applications for community-based physiotherapy clinics was also released by the MOHLTC. The applications were reviewed by the LHIN and the MOHLTC to enhance access to community-based physiotherapy clinics especially in previously underserviced areas. This planning enabled an additional 3,891 episodes of physiotherapy care to be available to LHIN residents at 14 additional community-based clinics, community health centres and family health teams.

- The fifth area, primary care, continues to be developed for rollout in early 2014-15 fiscal year.

Wait Times Strategy

In January 2012, the Ministry of Health and Long-Term Care (MOHLTC) initiated its Health System Funding Reform (HSFR) strategy. Initially impacting hospitals and the HNHB Community Care Access Centre (CCAC), HSFR's goal is to introduce patient based activity funding. Through this strategy, health service providers will be funded based on the number and complexity of procedures completed rather than base budget increases annually.

This shift in funding will have a positive impact on access and quality of care for procedures such as cancer, cardiac surgery, joint replacement, cataract services and for complex medical conditions such as stroke, congestive heart failure, and chronic obstructive pulmonary disease.

The HNHB LHIN is fortunate to have individuals within our region with considerable expertise and knowledge in clinical practice, data management, and quality improvement. In 2013-14 individuals from directly impacted hospitals and the HNHB CCAC created a Local Partnership (HSFR-LP) Committee to plan and execute key changes associated with this new funding regime. By working as partners, LHIN providers share best practices and mitigate risks as new funding models are implemented. This benefits system efficiency and the quality of care delivered to patients.

In addition to this work on HSFR, the LHIN continues to support the Wait Times Strategy, together with its health service providers across all sectors, also undertook the following activities:

- Implemented hospital specific improvement strategies to reduce wait times, particularly in emergency departments and diagnostic imaging.
- Monitored wait time trends throughout the year to determine areas of need and implement local and/or LHIN-based solutions, which included reallocating funding based on need.
- Provided stakeholders the education and information to monitor performance and support ongoing improvements.
- Facilitated joint discussion to identify inequities, reduce variations in service and support quality improvement plans both within and between hospitals to maximize volume capacity and improve patient flow.
- Worked closely with provincial programs to ensure optimal cancer and cardiac services every step of the way.

Performance Indicators

Performance Indicator	LHIN 2013/14 Starting Point	LHIN 2013/14 Performance Target	Most Recent Quarter 2013/14 LHIN Performance	FY 2013/14 LHIN Annual Result
Access to Healthcare Services				
1. 90th percentile ER length of stay for admitted patients	35.63	28.00	42.00	37.52
• In 2013-14, the HNHB LHIN continued to be challenged to make sustainable improvements in this metric. Eight of the LHIN's 12 emergency rooms reported annual 90th percentile length of stays (LOS) higher than the MLPA target of 28 hours. • Factors contributing to the higher LOSs included an increase in the number of individuals admitted to the hospital through the ER and an increasing trend in the number of individuals waiting in hospital for an alternate level of care. • Four LHIN hospital ER sites (Joseph Brant Hospital and Niagara Health System - St. Catharines, Welland and Niagara General) that account for 36% of the LHINs ED admitted population, continue to be the most challenged in achieving improvements for this metric reporting length of stays from 48.7 hours to 58.1 hours. Joseph Brant Hospital saw an increased LOS for Q3 (from 46.1 hours in Q2 to 65.4 hours in Q3). • To assist these two hospital organizations, targeted initiatives were implemented. An ED Coaching Team comprised of senior administration (CEO and VP) team from North York General Hospital spent 2 days at JBH at the end of January. JBH has developed an Action Plan based on their recommendations. In February 2014, the LHIN retained Process Improvement Facilitator (Lean Six Sigma Black Belt Coach) to work with Niagara Health System to identify barriers and opportunities to improve patient flow. • The LHIN is working with the HNHB Emergency Services Steering Committee and hospitals to reduce the ER admitted LOS.				
2. 90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	7.80	7.50	7.55	7.47
• In 2013-14 the LHIN met the MLPA target for this metric. HNHB LHIN hospitals' initiatives targeting this metric included: comprehensive reviews of patient flow in the ER, refinement of staffing models to meet ER volume demand, and focused efforts to serve the low-acuity patients. • Seven of the LHIN's 12 ER sites reported LOS higher than the LHIN target. This metric is influenced by increased numbers patients waiting in the ER to be admitted to the hospital and increased in the number of individuals triaged as high acuity (CTAS 1, 2, 3).				
3. 90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	4.87	4.50	4.47	4.43
• In 2013-14 the HNHB LHIN met the MLPA target for this metric. HNHB LHIN hospitals' initiatives targeting this metric included: structured information sharing between sites for coaching purposes; meeting with particular hospital corporations to review strategies for modifying the process flow for patients with lower acuity needs; updating and expanding medical directives across the LHIN to help expedite tests and treatments for low acuity patients; and increased public information and education on the alternatives to going to an ED (i.e. Urgent Care Centres, Primary Care, local clinics). • Nine of the LHIN's 12 ER sites reported LOS higher than the LHIN target reporting LOS ranging from 4.6 to 5.9 hours.				
4. Percent of priority IV cases completed within access target (84 days) for cancer	85.00%	90.00%	90.07%	90.19%

surgery				
• In 2013-14, the HNHB LHIN exceeded the MLPA target this metric and performance was improved by 6% (5 percentage points) over the previous fiscal year. • The HNHB LHIN continues to work with hospitals and our Regional Cancer Centre to meet and exceed this target for timely access to cancer surgery for our residents. The LHIN continues to actively monitor wait times with a focus on the Cancer Clinical Services Plan to support standardization and improved access for patients. • The Cancer Clinical Services Plan has improved the regional organization of surgical oncology by disease and satellite cancer services for systemic therapy are now operating across the HNHB LHIN. • Active performance monitoring with the LHIN and hospitals, allows hospitals to target specific surgeries when challenges are noted. Work continues with hospital providers to target key populations and surgery types to increase timely access to surgery.				
5. Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	97.80%	90.00%	100.00%	98.00%
• In 2013-14, the HNHB LHIN exceeded the MLPA target this metric. This indicator only reports on the wait time for elective cardiac bypass surgery. • Hamilton Health Sciences Corporation – General Site is the sole provider for cardiac surgery in the HNHB LHIN.				
6. Percent of priority IV cases completed within access target (182 days) for cataract surgery	87.00%	90.00%	87.69%	87.03%
• The HNHB LHIN was challenged to meet the MLPA target for this metric in 2013-14. • Hospital providers and data continue to support that demand for this service has exceeded the supply of surgeries available through the Quality-Based Procedure (QBP) allocation to the HNHB LHIN. This has negatively impacted wait times for our residents. As such, additional ministry funding for 2000 cataract surgeries was provided in the final quarter of 2013-14 to help address cataract surgery pressures. These additional surgeries were completed with a focus on prioritizing surgery for patients who were past the 182 day target. • Three of the five HNHB facilities that perform Cataract surgery achieved the target in FY2013-14, with two sites completing 99% of cases within the provincial access target of 182 days. • The HNHB LHIN reviewed performance data across all hospitals to identify opportunities for increased standardization to improve access for patients. The formation of a LHIN-Wide Ophthalmology Steering Committee in 2013-14 and development of a LHIN-Wide clinical services plan, available on the LHIN website, will facilitate the progress of this work and further improvements in 2014-15. • The LHIN has continued to work with all hospital providers to develop a LHIN-Wide focused utilization of data to facilitate wait-list management. Data has included analysis of use of Dates Affecting Readiness to Treat (DARTs), two day business rule compliance levels for opening and closing surgical cases, long wait case analysis and transparent sharing of physician wait lists for cataract surgery at hospitals to facilitate referrals to the shortest surgical wait when possible.				
7. Percent of priority IV cases completed within access target (182 days) for hip replacement	77.00%	85.00%	78.84%	79.92%
• In 2013-14, the HNHB LHIN performance target was altered mid-year by the ministry. Previously, this target focused on the 90th percentile wait times for Priority 2, 3 and 4 cases. The new target requires 85% of Priority 4 (P4) cases be completed within 182 days from the date a decision to operate is made. • The HNHB LHIN improved in performance towards meeting this target in 2013/14. • Factors contributing towards delayed access include: referral patterns, patient preference, a backlog of patients waiting for surgery and ongoing demand which limits the ability to clear backlog. • Guided by the Integrated Orthopedic Capacity Plan, initiatives have been put in place to reduce variation and support best practice. An Orthopedic Leadership Committee has been established to maximize regional integration and, support standardization and greater efficiency. More specifically, standardized physician order sets, patient care pathways, and patient education material have been implemented				

across the LHIN.

- Other initiatives include optimizing data management, wait list management, and participation in the Regional Joint Assessment Program, all towards ensuring patients are offered and provided the first available surgical date.
- Performance is reviewed with hospitals at minimum on a monthly basis and more frequently as specific issues is noted.

8. Percent of priority IV cases completed within access target (182 days) for knee replacement	64.00%	80.00%	75.28%	76.19%

- In 2013-14, the HNHB LHIN performance target was altered mid-year by the ministry. Previously, this target focused on the 90th percentile wait times for Priority 2, 3 and 4 cases. The new target requires 80% of Priority 4 (P4) cases be completed within 182 days from the date a decision to operate is made.
- The HNHB LHIN improved considerably in performance towards the target in 2013/14.
- Factors contributing towards delayed access include referral patterns, patient preference, a backlog of patients waiting for surgery and ongoing demand which limits the ability to clear backlog.
- Guided by the Integrated Orthopedic Capacity Plan, initiatives have been put in place to reduce variation and support best practice. An Orthopedic Leadership Committee has been established to maximize regional integration, and support standardization and greater efficiency. More specifically, standardized physician order sets, patient care pathways, and patient education material have been implemented across the LHIN.
- Other initiatives include optimizing data management, wait list management, and participation in the Regional Joint Assessment Program, all towards ensuring patients are offered and provided the first available surgical date.
- Performance is reviewed with hospitals at minimum on a monthly basis and more frequently as specific issues is noted.

9. Percent of priority IV cases completed within access target (28 days) for MRI scans	45.00%	60.00%	35.65%	31.75%

- The HNHB LHIN was challenged to meet the new MLPA target for this metric in 2013-14, although fourth quarter results were improved by 10% from third quarter results.
- In 2013-14, the HNHB LHIN performance target was altered mid-year by the ministry. Previously, this target focused on the 90th percentile wait times for Priority 2, 3 and 4 cases, and the HNHB LHIN performed 9th out of 14 LHINs for this target. HNHB LHIN performance for the new target resulted in a performance of 13th out of 14 LHINs for this target. Data analysis and hospital reports continue to support an increasing demand for MRI from community physicians, as well as increased use of MRIs for emerging/new best practice scan types (i.e. prostate). Demand for more medically urgent scans (Priorities 1, 2 and 3) reduce hospital capacity to complete less urgent scans (Priority 4). As MRI scan demand continues to exceed the supply of funded MRI hours, a backlog of patients waiting has resulted.
- The LHIN meets weekly with Diagnostic Imaging Directors from hospitals to identify and facilitate adoption of best practices to further improve MRI efficiencies LHIN-Wide, and to constantly monitor facility data transparently with all hospitals. Development of a LHIN-Wide Diagnostic Imaging Steering Committee this year will further facilitate ongoing achievement of best practice adoption across the LHIN to further maximize efficiencies.
- This year, an additional 2000 hours were received from the ministry to facilitate completion of long wait Priority 4 cases. These cases were distributed based on a mixed model accounting for patient needs, as demonstrated by longest waits, as well as hospital efficiency for MRI service delivery. This methodology resulted in a reduction of Priority 4 wait time variation (difference between the hospital with longest wait and the hospital with the shortest wait) amongst facilities from 69 days of variance to 27 days of variance, a significant improvement for residents based on LHIN facilitated data driven analysis and decision

making.				
10. Percent of priority IV cases completed within access target (28 days) for CT scans	68.00%	82.00%	77.54%	76.50%
• The HNHB LHIN improved considerably in performance toward the MLPA target for this metric in 2013-14. • In 2013-14, the HNHB LHIN performance target was altered mid-year by the ministry. Previously, this target focused on the 90th percentile wait times for Priority 2, 3 and 4 cases, and the HNHB LHIN performed 9th out of 14 LHINs for this target, and this performance has remained consistent for the new target. Data analysis and hospital reports continue to support an increasing demand for CT from community and hospital physicians for all priorities of scans. Demand for more medically urgent scans (Priorities 1, 2 and 3) reduce hospital capacity to complete less urgent scans (Priority 4). With demand for scans exceeding the supply available, a backlog in patients waiting for CT scans resulted. • Two of the six HNHB facilities that perform CT scans achieved the target in FY2013-14, completing 90% or more cases within the provincial access target of 28 days. Specifically, Niagara Health System improved from 52% in FY 2012-13 to 90% in FY 2013-14, a relative increase of 73%. • The LHIN meets weekly with Diagnostic Imaging Directors from hospitals to identify and facilitate adoption of best practices to further improve CT performance LHIN-Wide, and to constantly monitor facility data transparently with all hospitals. Development of a LHIN-Wide Diagnostic Imaging Steering Committee this year will further facilitate ongoing achievement of best practice adoption across the LHIN to further maximize efficiencies in service across the LHIN to improve patient's timely access to care.				
Integration and Coordination of Care				
11. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	13.89%	12.00%	15.37%	14.54%
• In 2013-14, the LHIN did not meet is MLPA target for this metric. Patient flow and the number of patients waiting in hospital for an Alternate Level of Care (ALC) continue to be a priority for the HNHB LHIN. The LHIN has a very active Patient Flow Steering Committee that meets monthly to review standardized metrics and develop strategies aimed at improving patient flow and achieving the MLPA target. • In 2013-14, LHIN hospitals experienced an increasing trend in the number of individuals waiting in hospital for an ALC. From April to November 2013, the number of individuals waiting in hospital for an ALC increased from 409 – 535 (Source HNHB CCAC November 2013). In addition, between April and June 2013, LHIN hospitals saw an increase in the number of individuals admitted to the hospital through the ER (870 more patients admitted in Q1 2013-14 compared to Q1 2012-13). Hamilton hospitals accounted for just over 72% of this increase. • In 2013-14, the HNHB LHIN funded several strategies to support patient flow: o Additional $21M in funding to HNHB CCAC to support clients in the community o Expanded convalescent care by 28 additional beds o Supported 99 Assess Restore beds and 25 Slow steam rehab beds across the LHIN o Temporarily opened additional hospital capacity at West Haldimand General Hospital to offset some of the surge experienced at HHS from SJHH during a flood at the SJHH. o Approved 3 additional assisted living hubs (two in Hamilton and one in Burlington) and 2 transitional bed programs in Brant and Hamilton. • The LHIN continues to work with HSPs to improve patient flow and performance. CCAC is actively working with Retirement Homes in all LHIN zones to look for opportunities for congregate settings where individuals could be supported while awaiting for LTCH placement and the. • Targeted strategies to address patient flow challenges included: 1) recruiting a Process Improvement Facilitator (Black Belt) to work with the Niagara Health System (as noted under ER) and 2) seconding an individual to work stakeholders in Hamilton to identify opportunities to support congregate wellness settings in the community.				
12. 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service	26.00	26.00	30.00	32.00

(excluding case management)*				
• In 2013-14, the LHIN did not meet its MLPA target for this metric. The main factor contributing to the LHIN's performance was the changes implemented by the Ministry of Health and Long Term Care related to publicly funded physiotherapy services. As part of this initiative, CCACs assumed the responsibility for provision of in home publicly funded physiotherapy services. CCACs across the province saw an increase in client volumes which impacted wait times. For the HNHB LHIN the 90th percentile wait time for physiotherapy services increased by 18 days at Q2 (from 39 days at Q1 to 57 days at Q2) and the episode volumes increased by 962 (301 at Q1 to 1245 at Q2). Wait times and volumes for other CCAC services included in this metric remained relatively stable. • The LHIN is working with the CCAC to gain a better understanding of the population that experienced longer wait times and future demand for this service.				
Quality and Improved Health Outcomes				
13. Readmission within 30 Days for Selected CMGs**	16.40%	15.40%	16.21%	16.14%
• In 2013-14, the LHIN did not meet its MLPA target for this metric. The HNHB LHIN has demonstrated an improvement in readmissions within 30 days for selected CMGs in each quarter since Q3 11/12, with two exceptions: Q4 12/13 and the most recent data for Q2 13/14. • In Q2 13/14, the HNHB LHIN was 0.8% above the target rate of readmission within 30 days for selected CMGs of 15.4%. • The LHIN anticipates a reduction in readmissions within 30 days for selected CMGs by Q4 13/14. By that time, LHIN-wide initiatives aimed at improving the coordination of follow up care for chronic conditions will be further along in their implementation. These initiatives include the: Discharge Transition Bundle DTB teach back materials for COPD and CHF and four community-based COPD clinics.				
14. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	18.40%	17.00%	18.74%	18.09%
• In 2013-14, the LHIN did not meet its MLPA target for this metric. The HNHB LHIN continues to demonstrate lower repeat visits within 30 days for mental health conditions compared to the province. This indicator has shown an overall annual improvement of 1.7% (from 18.40% to 18.09%) in repeat unscheduled emergency visits within 30 days for mental health conditions. • The conditions driving performance on this metric include: people with mood disorders and stress-related or neurotic conditions. • The Mental Health and Addictions Advisory Group will guide the implementation of a standardized scorecard with metrics for hospital and community as a mechanism for improved performance.				
15. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	23.90%	22.70%	23.98%	24.96%
• In 2013-14, the LHIN did not meet its MLPA target for this metric. Compared to the province, the HNHB LHIN continues to demonstrate lower repeat visits within 30 days for substance abuse conditions. • An increase in repeat visits within 30 days was observed in Q2 13-14 to 27.3% and has Q3 performance has since decreased to 23.98%. Repeat emergency department visits for alcohol use within 30 days drives performance for this metric. • The Mental Health and Addictions Advisory Group identified concurrent disorders as a targeted priority population for the LHIN, and specific strategies have been identified to improve performance.				

*FY 2013/14 is based on most recent four quarters of data (Q4 2012/13 - Q3 2013/14) due to availability
**FY 2013/14 is based on most recent four quarters of data (Q3 2012/13 - Q2 2013/14) due to availability

Financial statements of

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2014

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2014

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Independent Auditor's Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant
Local Health Integration Network

We have audited the accompanying financial statements of Hamilton Niagara Haldimand Brant Local Health Integration Network, which comprise the statements of financial position as at March 31, 2014, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Hamilton Niagara Haldimand Brant Local Health Integration Network, as at March 31, 2014 and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 28, 2014

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial position
as at March 31, 2014

	2014	2013
	$	$
Financial assets		
Cash	**756,953**	521,790
HST receivable	**32,205**	20,926
Accounts receivable - other	**942**	16,627
Due from Ministry of Health and Long-Term Care ("MOHLTC") transfer payments to Health Service Providers ("HSPs") (Note 9)	**49,450,245**	11,936,000
	50,240,345	12,495,343
Liabilities		
Accounts payable and accrued liabilities	**367,510**	223,768
Due to the MOHLTC (Note 3b)	**428,415**	361,391
Due to Health Service Providers ("HSPs") (Note 9)	**49,450,245**	11,936,000
Due to the LHIN Shared Services Office (Note 4)	**2,107**	9,196
Deferred capital contributions (Note 5)	**69,170**	19,088
	50,317,447	12,549,443
Commitments (Note 6)		
Net debt	**(77,102)**	(54,100)
Non-financial assets		
Prepaid expenses	**7,932**	35,012
Tangible capital assets (Note 7)	**69,170**	19,088
Accumulated surplus	**-**	-

Approved by the Board

_____ Director

_____ Director

The accompanying notes to the financial statements are an integral part of these financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of operations
year ended March 31, 2014

	Budget (Note 8)	2014 Actual	2013 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	2,808,565,700	2,836,986,207	2,737,118,195
Operations of LHIN	4,916,172	4,855,909	4,916,172
Enabling Technologies (Note 10a)	580,000	580,000	580,000
ER/ALC Performance Lead (Note 10b)	-	100,000	100,000
French Language Services (Note 10c)	-	76,266	106,000
French Language Planning Entity (Note 10c)	-	411,693	411,693
Emergency Dept LHIN LEAD (Note 10d)	-	75,000	75,000
Critical Care LHIN LEAD (Note 10e)	-	75,000	75,000
Aboriginal Planning (Note 10g)	37,500	37,500	37,500
Primary Care LHIN Lead (Note 10f)	-	75,000	75,000
Diabeties Education (Note 10h)	-	841,301	140,396
Physiotherapy (Note 10i)	-	27,344	-
Amortization of deferred capital contributions (Note 5)	10,093	40,181	153,534
	2,814,109,465	2,844,181,401	2,743,788,490
Funding repayable to the MOHLTC (Note 3a)		(428,415)	(328,956)
	2,814,109,465	2,843,752,986	2,743,459,534
Expenses			
Transfer payments to HSPs (Note 9)	2,808,565,700	2,836,986,207	2,737,118,195
General and administrative (Note 11)	4,926,265	4,469,987	4,803,000
Enabling Technologies (Note 10a)	580,000	580,000	580,000
ER/ALC Performance Lead (Note 10b)	-	100,000	100,000
French Language Services (Note 10c)	-	76,266	101,432
French Language Planning Entity (Note 10c)	-	411,693	446,113
Emergency Dept LHIN LEAD (Note 10d)	-	75,000	75,000
Critical Care LHIN LEAD (Note 10e)	-	72,688	73,025
Aboriginal Planning (Note 10g)	37,500	37,500	37,500
Primary Care LHIN Lead (Note 10f)	-	75,000	68,750
Diabeties Education (Note 10h)	-	841,301	56,519
Physiotherapy (Note 10i)	-	27,344	-
	2,814,109,465	2,843,752,986	2,743,459,534
Annual surplus and closing accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of change in net debt
year ended March 31, 2014

	2014		2013
	Budget (Note 8)	Actual	Actual
	$	$	$
Annual surplus	-	-	-
Change in prepaid expenses	-	27,080	(8,564)
Acquisition of tangible capital assets	-	(90,263)	(17,321)
Amortization of tangible capital assets	-	40,181	153,534
(Increase) decrease in net debt	-	(23,002)	127,649
Net debt, beginning of year	-	(54,100)	(181,749)
Net debt, end of year	-	(77,102)	(54,100)

The accompanying notes to the financial statements are an integral part of these financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of cash flows
year ended March 31, 2014

	2014	2013
	$	$
Operating transactions		
Annual surplus	-	-
Add items not affecting cash		
Amortization of capital assets	**40,181**	156,666
Less items not affecting cash		
Amortization of deferred capital contributions	**(40,181)**	(156,666)
Changes in non-cash operating items		
Decrease in accounts receivable - other	**15,685**	76,364
Decrease in accounts receivable - MOHLTC / e-Health	**-**	200,000
(Increase) decrease in HST receivable	**(11,279)**	11,372
(Increase) in due from MOHLTC to HSPs	**(37,514,245)**	(6,643,560)
Increase (decrease) in accounts payable and accrued liabilities	**143,742**	(629,442)
Increase (decrease) in due to the MOHLTC	**67,024**	(274,097)
Increase in due to HSPs from MOHLTC	**37,514,245**	6,643,560
(Decrease) increase in due to the LHIN Shared Services Office	**(7,089)**	9,196
Decrease (increase) in prepaid expenses	**27,080**	(8,564)
	235,163	(615,171)
Capital investment		
Acquisition of tangible capital assets	**(90,263)**	(17,321)
Financing transaction		
Capital contributions received	**90,263**	17,321
Net change in cash	**235,163**	(615,171)
Cash, beginning of year	**521,790**	1,136,961
Cash, end of year	**756,953**	521,790

The accompanying notes to the financial statements are an integral part of these financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Notes to the financial statements
March 31, 2014

1. Description of business

The Hamilton Niagara Haldimand Brant Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry - LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC"). These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2014.

The LHIN has also entered into an Accountability Agreement with the MOHLTC, which provides the framework for LHIN accountabilities and activities.

The LHIN statements do not include any MOHTLC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian Public Sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

2. Significant accounting policies (continued)

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

			2014	2013
	Funding received	**Eligible expenses**	**Excess funding**	Excess funding
	$	**$**	**$**	$
Transfer payments to HSPs	**2,787,535,962**	**2,787,535,962**	**-**	-
LHIN operations	**4,896,091**	**4,465,053**	**426,103**	266,706
LHIN ETI	**580,000**	**580,000**	**-**	-
French Language Planning Entity	**411,693**	**411,693**	**-**	(34,420)
French Language Services	**76,266**	**76,266**	**-**	4,568
ER/ALC Performance Lead	**100,000**	**100,000**	**-**	-
Emergency Dept. LHIN LEAD	**75,000**	**75,000**	**-**	-
Critical Care LHIN LEAD	**75,000**	**72,688**	**2,312**	1,975
Primary Care Lead	**75,000**	**75,000**	**-**	6,250
Aboriginal Planning	**37,500**	**37,500**	**-**	-
Diabetes Education	**841,301**	**841,301**	**-**	-
Physiotherapy	**27,344**	**27,344**	**-**	83,877
	2,794,731,157	**2,794,297,807**	**428,415**	328,956

3. Funding repayable to the MOHLTC (continued)

b) The amount due to the MOHLTC at March 31, 2014 is made up as follows:

	2014	2013
	$	$
Due to MOHLTC, beginning of year	**361,391**	635,488
Prior year BSO funds not spent	**-**	32,435
Funding repayable related to current year activities to the MOHLTC (Note 3a)	**428,215**	328,956
Amount recovered by the MOHLTC during the year	**(361,391)**	(635,488)
Due to MOHLTC, end of year	**428,215**	361,391

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end, are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared services agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2014	2013
	$	$
Balance, beginning of year	**19,088**	155,301
Capital contributions received during the year	**90,263**	17,321
Amortization for the year	**(40,181)**	(153,534)
Balance, end of year	**69,170**	19,088

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years are as follows:

	$
2015	172,786
2016	172,786
2017	172,786
2018	172,786
2019	120,383

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon LHIN funding received from MOHLTC.

7. Tangible capital assets

	Cost	Accumulated amortization	2014 Net book value	2013 Net book value
	$	$	$	$
Office equipment, furniture and fixtures	471,438	468,217	3,221	-
Computer equipment	237,165	171,216	65,949	17,989
Leasehold improvements	572,444	572,444	-	1,099
	1,281,047	1,211,877	69,170	19,088

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of operations reflect the initial budget at April 1, 2013. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $ 2,836,986,207 is derived as follows:

	$
Initial budget	2,808,565,700
Adjustment due to announcements made during the year	28,420,507
Final budget	2,836,986,207

The final LHIN general and administrative budget of $7,217,666 is derived as follows:

	$
Initial budget	
LHIN operations	4,916,172
LHIN ETI	580,000
Aboriginal Planning	37,500
Additional funding received during the year for:	
French Language Planning Entity	411,693
French Language Services Coordinator	106,000
ER/ALC Performance Lead	100,000
Emergency Dept. LHIN LEAD	75,000
Critical Care LHIN LEAD	75,000
Primary Care Lead	75,000
Diabetes Education	841,301
Final budget	7,217,666

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,836,986,207 (2013 - $2,737,118,195) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2014 as follows:

	2014	2013
	$	$
Operation of hospitals	**1,892,233,026**	1,850,871,086
Grants to compensate for municipal taxation - public hospitals	**464,025**	464,025
Long term care homes	**460,634,986**	441,245,153
Community care access centres	**302,761,326**	272,408,894
Community support services	**45,063,756**	42,928,049
Acquired brain injury	**6,987,746**	6,654,450
Assisted living services in supportive housing	**30,250,506**	28,557,365
Community health centres	**25,416,149**	23,311,898
Community mental health addictions program	**73,174,687**	70,677,275
	2,836,986,207	2,737,118,195

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As of March 31, 2014 an amount of $49,450,245 (2013 - $11,936,000) was payable to the HSPs. This amount has been reflected as revenue and expenses within the LHIN's operations and is included above.

10. Other funding initiatives

a) *Enabling Technologies for Integration Project Management Office*

Effective January 31, 2014, the LHIN entered into an agreement with South West, Erie St. Clair and Waterloo Wellington LHIN's (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses.

The following provides condensed financial information:

		2014	2013
	Total	LHIN's portion	LHIN's portion
	$	$	$
Revenue	**2,320,000**	**580,000**	580,000
Expenses	**1,951,019**	**580,000**	580,000
Accumulated surplus	**368,981**	-	-

b) *ER/ALC Performance Lead*

During fiscal 2014, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $100,000 (2013 - $100,000). These funds were used to support the activities of the ER/ALC Coordinator.

10. Other funding initiatives (continued)

c) French Language Services

During fiscal 2014, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $487,959 (2013 - $517,693). Of this amount, $76,266 was used to support the French Language Services Coordinator role (2013 - $106,000) and $411,693 was included in the initial allocation for the French Language Planning Entity (2013 - $411,693).

d) Emergency Department LHIN LEAD

During fiscal 2014, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2013 - $75,000). These funds were used toward initiatives in support of Emergency Department LHIN LEAD activities.

e) Critical Care LHIN LEAD

During fiscal 2014, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2013 - $75,000). These funds were used toward initiatives in support of Critical Care LHIN LEAD activities.

f) Primary Care LHIN LEAD

During fiscal 2014, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $75,000 (2013 - $75,000). These funds were used toward initiatives in support of Primary Care LHIN LEAD activities.

g) Aboriginal Planning

During fiscal 2014, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $37,500 (2013 - $37,500). These funds were used to support Aboriginal Planning activities.

h) Diabetes Regional Coordination Centres

The LHIN received $841,301 (2013 - $157,717) related to the assumption of work plan deliverables for diabetes and chronic disease management planning effective February 1, 2013. During the year, $841,301 (2013 - $56,519) of expenses were incurred and capital asset purchases of $30,000 (2013- $17,321) have been recorded as capital assets and the related funding has been recorded as deferred capital contributions. Expenses incurred include the following:

	2014	2013
	$	$
Salaries	**700,109**	54,829
Operating expenses	**141,192**	1,690
General and administrative expenses	**841,301**	56,519
One-time expenses - Capital Purchases	**30,000**	17,321
Total	**871,301**	73,840

i) Physiotherapy

In July 2013 the Ministry of Health and Long Term Care provided one-time operations funding of $27,344 to the LHIN to carry out the activates supporting the implementation of physiotherapy reform. This funding was used for compensation for additional staff resources to act as a lead to carry out activities supporting implementation of Physiotherapy Reform within the in-home, exercise and falls prevention and community clinics streams.

11. Expenses by object

The Statement of operations presents the expenses by function. The following classifies general and administrative expenses by object:

	2014	2013
	$	$
Salaries and benefits	**3,258,641**	3,325,055
Board Chair per diems	**29,621**	18,239
Directors' per diems	**30,875**	33,956
Board expenses	**10,393**	6,159
Travel	**26,087**	32,734
Consulting services	**168,140**	281,905
Community forums and communication	**46,092**	65,795
Supplies, equipment, maintenance, other	**88,645**	71,788
Occupancy costs	**244,752**	296,355
Amortization	**40,181**	153,534
Shared services	**526,559**	517,480
General and administrative expenses	**4,469,987**	4,803,000
Salaries and benefits	**986,210**	260,207
Travel	**8,554**	5,063
Contracted Services	**1,170,613**	1,251,312
Community forums and communication	**28,992**	19,682
Supplies, equipment, maintenance, other	**21,032**	385
Occupancy costs	**30,391**	-
Shared services	**51,000**	1,690
Other funding initiatives expenses	**2,296,792**	1,538,339
	6,766,779	6,341,339

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of 35 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2014 was $289,995 (2013 - $276,088) for current service costs and is included as an expense in the Statement of operations. The last actuarial valuation was completed for the plan as at December 31, 2013. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act*, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

Board Members

(as of March 31, 2014)

Michael P. Shea
Chair

Bob Lawler
Vice Chair

Ruby Jacobs
Board Member

Helen Mulligan
Board Member

Laurie Ryan-Hill
Board Member

Mervin Witter
Board Member

Senior Staff Member

Donna Cripps
Chief Executive Officer

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2014.

Originally signed by

Michael P. Shea
Chair, Board of Directors

Originally signed by

Bob Lawler
Vice Chair, Board of Directors

Hamilton Niagara Haldimand Brant **LHIN**
RLISS de Hamilton Niagara Haldimand Brant

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